Welcome to Slak Chiropractic Group!

Dr. Jean-Marc Slak, DC
Dr. Linda Eisen-Slak, DC

23 Adams Street
Burlington, MA 01803
781-273-0099

ABOUT YOU

Today's Date:_____ ☐ Male ☐ Female

Name:_____

What do you prefer to be called?_____

Birthdate:_____ Age:_____ Occupation:_____

Address:_____ City:_____ Zip Code:_____

Email Address:_____

Home Phone #:_____ Work #:_____ Cell #: _____

Emergency Contact:_____ Relation to you:_____ Phone #_____

Referred By:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Do you have children: ☐Yes ☐No How many?_____

What is your current weight?_____Lbs. Height?_____Feet_____Inches

REASON FOR VISIT

Is your problem a result of: ☐Work ☐Sports ☐Auto ☐Trauma ☐Chronic

Explain what happened:_____

Please describe the problem & its location:_____

_____

When did condition begin?_____

Is this condition getting worse? ☐Yes ☐No ☐Constant ☐Comes & goes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine

If so, please explain:_____

Have you had this or similar conditions in the past? ☐Yes ☐No

If so, please explain:_____

Have you been treated for this condition? ☐Yes ☐No

If so, where?_____

 For office use: Scan____

Name:_____Today's Date:_____

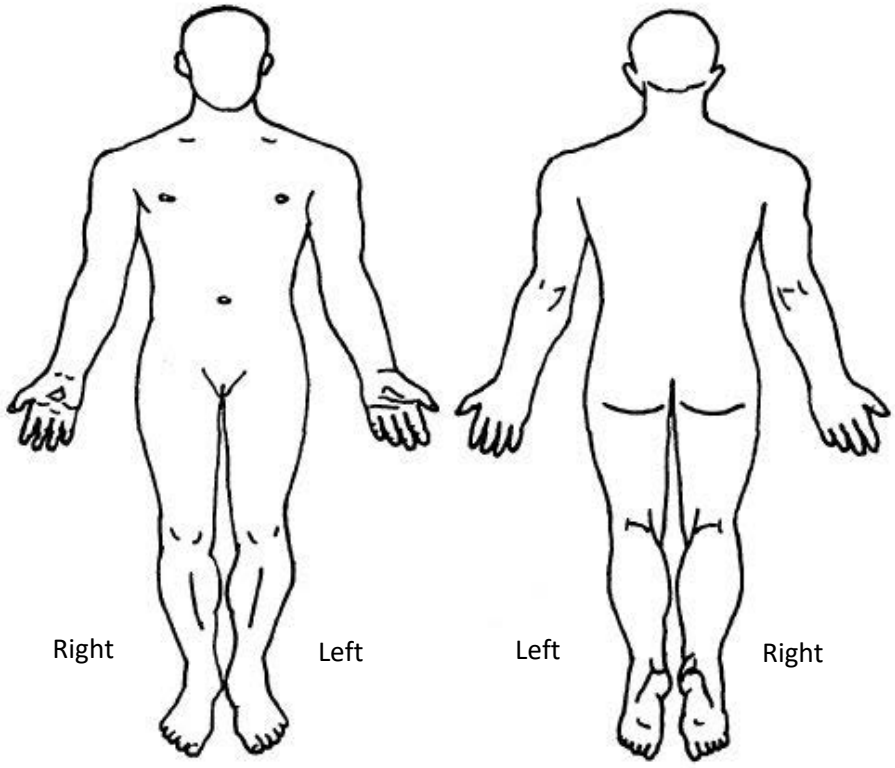
Have you ever been under a Chiropractor's care before? ☐Yes ☐No

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort. Mark with the appropriate symbols and indicate degree of pain as follows:

(Mild discomfort) **1-------2-------3-------4-------5-------6-------7-------8-------9-------10** (Extreme pain)

Numbness = **N** Pins & Needles = **P** Burning = **B** Aching = **A** Stabbing = **S** **Example: "S4" or "A9"**



HEALTH HISTORY

Do you have or have you ever had any of the following conditions? (please check off)

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ HIV+/AIDS
- ☐ Frequent Neck Pain
- ☐ High/Low Blood Pressure
- ☐ Severe/Frequent Headaches
- ☐ Fainting/Seizures/Epilepsy
- ☐ Heart Surgery/Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Difficulty Breathing
- ☐ Lower Back Problems
- ☐ Emphysema/Glaucoma
- ☐ Psychiatric Problems
- ☐ Kidney Problems
- ☐ Sinus Problems
- ☐ Diabetes/Tuberculosis
- ☐ Artificial Valves
- ☐ Hepatitis
- ☐ Cancer
- ☐ Artificial Bones/Joints
- ☐ Rheumatic Fever
- ☐ Ulcers/Colitis
- ☐ Asthma
- ☐ Heart Murmur
- ☐ Chemotherapy
- ☐ STD
- ☐ Shingles
- ☐ Anemia

For office use: Scan____

Name:_____Today's Date:_____

Who is your Medical Doctor?_____Phone #:_____

May we have permission to contact your doctor? ☐Yes ☐No

Are you taking any: Prescription Drugs (please list)_____

Over the Counter Drugs (please list)_____

Please list any other serious medical condition(s) you have or ever had:_____

_____

Please list anything to which you may be allergic:_____

List previous surgeries/treatments with dates:_____

_____

List any past accidents, injuries, or broken bones with dates:_____

_____

Family health history:_____

_____

Do you take any supplements or vitamins? ☐Yes ☐No Do you exercise? ☐Yes ☐No

Are you on a special diet? ☐No ☐Yes Type:_____ Do you smoke? ☐No ☐Yes

For Women: Are you taking Birth Control? ☐Yes ☐No

Are you pregnant? ☐No ☐Yes/How many weeks?_____ Are you nursing? ☐Yes ☐No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

- I authorize the staff of Slak Chiropractic Group to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____Date:_____

Adult Patient Parent or Guardian Spouse

For office use: Scan____

SLAK CHIROPRACTIC
Wellness for the Whole Family

Non-Covered Service Waiver Form

For the Patient

I understand that I am responsible for all costs associated with chiropractic care, ancillary services, maintenance and wellness visits. This notice informs me that my insurance company may not pay for certain services including some supportive therapies, maintenance and wellness visits because my insurance company does not consider them covered services or medically necessary.

Member Name: X_____

Member ID Number: _____

Member Signature: X _____ Date: X _____

For the provider

I verify that I have informed my patient _____ that their insurance company does not allow payment for certain supportive therapies, maintenance and wellness visits because they do not consider them covered services or medically necessary.

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INFORMED CONSENT

Slak Chiropractic Group

Patient Name Printed: X_____ File #: _____

Chiropractic is the science of locating, and removing interference with the transmission or expression of nerve force in the human body, by the correction of misalignments or subluxations of the bony articulations and adjacent structures more especially those of the vertebra column and pelvis, for the purpose of restoring and maintaining health. Chiropractic recognizes that essentially only the body heals and, therefore, holds forth no cure for disease and does not guarantee any specific result. The primary chiropractic examination finding is the Vertebral Subluxation and the primary chiropractic procedure is the chiropractic adjustment, performed manually and/or with a manual device.

The material risks inherent in the chiropractic adjustment and examination: There are potential complications with any health care procedure. The most common side effect is stiffness and soreness and moving of symptoms during the first few weeks of care. Bruising can occur. Rare complications include fractures, disc injuries, dislocations, paralysis, strains and sprains. Some techniques used to manipulate the cervical spine (neck region) have been implicated in injury to the arteries in the neck leading to, or contributing to, serious complications that includes stroke. One prominent authority states that there is, at most, a one-in-a-million chance of such an outcome.

Ancillary procedures and additional risks: Ancillary procedures sometimes used include light, vibration, massage, and therapeutic exercise. Vibration, massage, and exercise have risks similar to Chiropractic Adjustments; and vigorous exercise may pose a significant health risk to those with advanced cardiovascular disease.

Availability and nature of treatment options: Other treatment options include self-administered over-the-counter analgesics, rest, prescription drugs, hospitalization, surgery and rehabilitation. The material risks inherent in such options and the probability of such risks occurring are significant. Chiropractors may provide general information, but they do not provide medical advice. We strongly suggest that you consult a knowledgeable physician when making a decision to take or discontinue medications.

The risks and dangers attendant to remaining untreated: Remaining untreated may promote the formation of adhesions and reduction of mobility. A pain reaction may result that further reduces mobility. Over time this process may complicate treatment, making it more difficult and less effective, the longer it is postponed. The probability that non-treatment will later complicate rehabilitation is relatively high.

Payment for services: Co-pays, deductibles and cash balances are due before service is rendered. This is to keep you informed of charges before they are incurred and to provide faster service. Any over-payment is refunded.

X-RAYS

X_____ (patient initials) Recommended x-rays may be taken at any facility of your choosing.

- X-ray films are kept as part of your permanent medical record. Copies are available in digital format. Please allow 5-10 business days after written request.

Flare-ups and injuries: It is your responsibility to tell the treating chiropractor if you've had a flare-up or new injury, before he/she starts treating you.

CONSENT

I have read or have had read to me the above explanation of the chiropractic examination, adjustment and related treatment. I have discussed any questions I have with the attending chiropractor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits of treatment and have decided that it is in my best interest to undergo the treatment recommended and give my consent to the aforementioned examination and treatment.

X_____	_____	X_____	_____
Signature (guardian if a minor)	relationship of guardian to patient	Date	Witness

SLAK CHIROPRACTIC

Wellness for the Whole Family

AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests, and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells, or sounds, gently tapping) as well as physical touching. These tests and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination, less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENT: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient Name Printed	Date
Patient Signature	Authorized Provider Rep.
Personal Representative Printed	Personal Rep. Signature