CONCORD HEALTH CENTER

56 Winthrop Street
West Concord, MA, 01742
Phone: 978-369-2266
Fax: 978-369-5205
www.concordhealthcenter.com

PATIENT INSTRUCTIONS

We ask patients to arrive 15 minutes before your appointment time to prepare for your visit. Please print the new patient forms and fill them our before your visit. This will cut down on wait time and preparation time. These forms can be found on our website.

PARKING

There is plenty of free parking in the front of the building. If you need directions please feel free to call us at 978-369-2266.

HOURS OF OPERATION

Monday: 9:30am- 4:00pm
Tuesday: 9:00am-12:00pm 4:30pm- 8:00pm
Wednesday: 9:30am-4:00pm
Thursday: 9:00am-12:00pm 4:30pm-8:00pm
Friday: 7:30pm- 12:00pm
Saturday: 9:00am- 12:00pm

URGENT CARE

Monday: 4:00pm- 5:00pm
Tuesday: 12:00pm- 1:00pm
Wednesday: 4:00pm- 5:00pm
Thursday: 12:00pm- 1:00pm
Friday: 12:00pm- 1:00pm
Saturday: 12:00pm-1:00pm

MRI'S OR X-RAYS

If you have any recent MRIs done in the year prior to your visit please bring them to your appointment. CD copies are preferred over films of the MRIs or X-rays.

INSURANCE REFERRALS

If your insurance requires a referral to see a specialist, your are responsible for obtaining it from your primary care physician prior to your appointment and making sure we receive it. If we have not received the referral, you will be asked to sign a waiver stating that you are aware that you are being seen without a referral and no further appointments or diagnostic tests will be scheduled. Please fax all referrals to the Concord Health Center at 978-369-5205.

CO-PAYMENTS

If your insurance requires a co-payment it is due at the time of your appointment. We accept payment in the form of credit cards, personal checks, and cash. It is not unusual for bills to change once they have been processed through insurance. If you have any questions about insurance coverage or billing please call us at 978-369-2266.

PATIENT HISTORY & ASSESSMENT

PATIENT INFORMATION				
Patient's Last Name :	First:	Middle:	DOB:	Age:
Preferred contact number: ( )	Secondary phone number: ( )			
Mailing Address:				
E-Mail Address:				
Marital Status:	Student Status:	Weight:	Height:	
Insurance Subscriber name:		Subscriber DOB:		

PRIMARY CARE PHYSICIAN			
Name:	Address:	Phone:	Fax:

REFERRING PHYSICIAN			
Name:	Address:	Phone:	Fax:

HISTORY OF YOUR PAIN/SYMPTOMS

What are the main problem(s) you would like help with?

When did your symptoms start?

Please indicate where your pain/symptoms were initially located (ex. Neck, lower back)

What would you say your symptom ratio is?
% Spine % leg % arm (ex. 75% spine, 25% leg)

CIRCLE THE BEST ANSWER

1. What event(s) led to your original Symptoms**?**

Accident Cancer Work Injury No obvious cause Following an operation
Other:_____

2. Since the time of onset, my symptoms have:

Remained the same Became more severe Lessened in severity

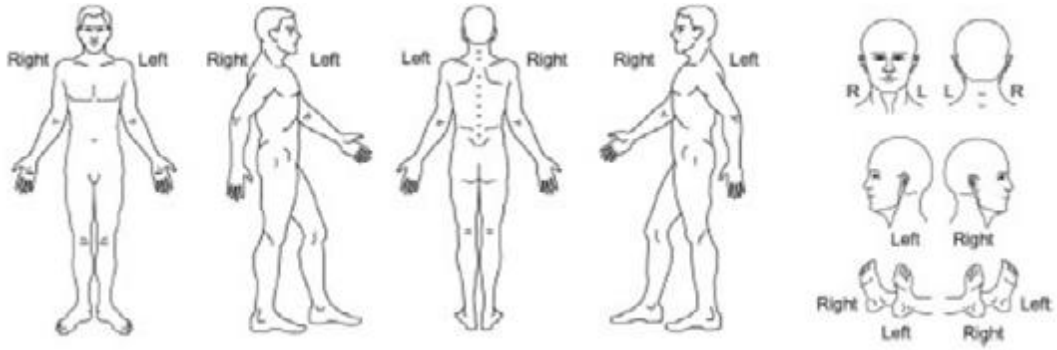
ACTIVITY

(Check the appropriate amount of time you can perform the following activities)

	Unable	15 minutes	30 minutes	45 minutes	60 minutes	Indefinitely
Sit						
Stand						
Walk						

PAIN DIAGRAM

(On the body diagram below indicate where your pain is located)



DESCRIPTION OF CURRENT PAIN

Date of current onset	**Pain frequency**	**Pain is worse**	**Your tolerance to pain**
/ /	❑ Constant ❑ Comes and Goes	❑ Morning ❑ Afternoon ❑ Evening ❑ Night	❑ Low ❑ Average ❑ High

Description of Pain(Check all that apply)

❑ Ache ❑ Dull ❑ Sharp ❑ Sting ❑ Tingle
❑ Burn ❑ Deep ❑ Superficial ❑ Swelling ❑ Throb

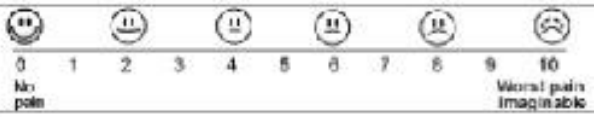
❑ Other (please describe)

What Relieves Pain (Check all that apply)

❑ Rest ❑ Cold ❑ Relaxation Technique ❑ Exercise
❑ Sleep ❑ Heat ❑ Repositioning ❑ Massage

❑ Other (please describe)

On a scale of 0 to 10 with 0 being no pain and 10 being the highest rate your pain now (Circle One)



When I have pain it makes me feel (Check all that apply)

❑ Sad ❑ Angry ❑ Anxious ❑ Tired ❑ Helpless

❑ Other (please describe)

What Makes Pain Feel Worse

What Makes Pain Feel Better

Patient Signature/Person Completing Form	**Date**	**Time**

PREVIOUS TREATMENTS

(Check and treatments you have tried for your current problem)

Treatment	Date	Did it help?	Treatment	Date	Did it help?
Nerve Blocks		❑ No ❑ Yes	Physical Therapy		❑ No ❑ Yes
Acupuncture		❑ No ❑ Yes	Psychotherapy		❑ No ❑ Yes
Chiropractor		❑ No ❑ Yes	Injections		❑ No ❑ Yes
Massage		❑ No ❑ Yes	Surgery		❑ No ❑ Yes
Brace/Collar		❑ No ❑ Yes	Other (specify)		❑ No ❑ Yes

PREVIOUS DIAGNOSTIC TESTING (Please enter any testing performed for your current problem)

Test	Date	Test	Date
MRI		Myelogram	
CT Scan		EMG/NCV	
X-Ray		Bone Scan	
Discogram		Other (specify)	

PAST MEDICAL HISTORY

(Check all that apply)

❑ High Blood Pressure	❑ High Cholesterol	❑ Diabetes	❑ Liver disease
❑ Heart Disease	❑ Sleep Apnea	❑ Seizures	❑ Cancer
❑ Asthma	❑ Bleeding problems	❑ Kidney disease	❑ Other _____

PAST SURGICAL HISTORY

Year	Describe	Hospital	Doctor

CURRENT MEDICATIONS

(List all medications you are currently taking including prescribed, over-the-counter, herbs and vitamins)

Medication Name	Dose/Frequency	Started	Prescribing MD

REVIEW OF SYSTEMS
(Check all that apply)

CONSTITUTIONAL ◯◯ Weight loss ◯◯ Loss of appetite ◯◯ Fatigue ◯◯ Fever, chills or sweats ◯◯ Recent Infections **EYES** ◯◯ Blurred/double vision ◯◯ Eye pain or irritation ◯◯ Dry eyes ◯◯ Failing vision **EARS, NOSE MOUTH AND THROAT** ◯◯ Difficulty hearing ◯◯ Ringing in ears ◯◯ Dry mouth ◯◯ Difficulty swallowing ◯◯ Frequent sore throat ◯◯ Frequent nose bleeds ◯◯ Sinus trouble ◯◯ Congestion **CARDIOVASCULAR** ◯◯ Heart murmur ◯◯ Chest pain ◯◯ Palpitations ◯◯ Shortness of breath ◯◯ Swollen ankles **ENDOCRINE** ◯◯ Cold hands/feet ◯◯ Thyroid Problem	**RESPIRATORY** ◯◯ Cough ◯◯ Wheezing **GASTROINTESTINAL** ◯◯ Nausea or vomiting ◯◯ Diarrhea ◯◯ Constipation ◯◯ Abdominal pain ◯◯ Ulcers ◯◯ Heartburn ◯◯ Jaundice (yellow skin) ◯◯ Black or bloody stools **GENITOURINARY** ◯◯ Frequent urination ◯◯ Pain with urination ◯◯ Blood in urine ◯◯ Bladder accidents ◯◯ Incontinence ◯◯ Kidney infection ◯◯ Kidney stones ◯◯ Bladder infections ◯◯ Erectile dysfunction **MUSCULATURE** ◯◯ Back pain ◯◯ Joint pain ◯◯ Joint swelling ◯◯ Muscle stiffness ◯◯ Arthritis ◯◯ Osteoporosis	**INTEGUMENTARY (SKIN)** ◯◯ Rash/ Sores ◯◯ Eczema ◯◯ Itching/ burning ◯◯ Acne **NEUROLOGICAL** ◯◯ Headaches ◯◯ Loss of strength ◯◯ Weakness ◯◯ Numbness ◯◯ Fainting spells ◯◯ Dizziness/ Vertigo **PSYCHIATRIC** ◯◯ Difficulty sleeping ◯◯ Anxiety/ Depression ◯◯ Mood Swings ◯◯ Memory loss **GYNECOLOGICAL** ◯◯ Painful periods ◯◯ Painful intercourse ◯◯ Pregnant ◯◯ Post-menopausal ◯◯ Last menstrual period date:_____

SOCIAL HISTORY

What is your occupation?

Working Status:

❑ Full Time ❑ Part Time (__ hours per week) ❑ Homemaker ❑ Retired _____ Years

❑ Unemployed _____ years due to pain ❑ Unemployed ____ years due to _____

How would you classify your occupation:

❑ Sedentary ❑ Light ❑ Medium ❑ Heavy

Are you on disability? · Yes · No	**Date Started:**	**Reason:**

Marital Status (please circle one) Divorced / Life Partner / Married / Single / Widow / Separated

Do you have any children? If so what ages:	❑ No ❑ Yes
Do you have any spiritual or cultural practices that you would like us to include in your care today?	❑ No ❑ Yes
Do you have any trouble understanding written or verbal instructions?	❑ No ❑ Yes
Have you had any difficulty caring for yourself at home over the last 3 months?	❑ No ❑ Yes
Is anyone in your personal life hurting you or making you feel unsafe?	❑ No ❑ Yes
Have you had a significant unexplained weight change (>15 pounds) in the last 3 months?	❑ No ❑ Yes
Have you experienced significant stress this past year? If yes, please explain:	❑ No ❑ Yes
Do you have any pending health related litigations?	❑ No ❑ Yes

BEHAVIORAL HEALTH

Do you smoke? If yes how much:	❑ No ❑ Yes
Do you drink more than **two** alcoholic beverages per day on a **DAILY** basis?	❑ No ❑ Yes
Do you use street drugs/narcotics? If yes, please explain:	❑ No ❑ Yes

FALL RISK ASSESSMENT

Have you fallen in the last (6) months (not a slip or a trip)?	❑ No ❑ Yes
Are you feeling weak, dizzy, or lightheaded today?	❑ No ❑ Yes
Do you need help to walk or change your clothes?	❑ No ❑ Yes
Have you ever experienced lightheadedness or dizziness before or after having your blood drawn or having an IV started?	❑ No ❑ Yes

FUNCTIONAL STATUS

Do you use? ❑ Cane ❑ Walker ❑ Braces ❑ Wheelchair ❑ None of these

Do you exercise? ❑ No ❑ Yes If so what type:

How many days per week do you exercise?

How long do you exercise each time (on average)?

CONCORD HEALTH CENTER
INFORMED CONSENT FORM FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures to be performed on myself, or the patient named below, for whom I am legally responsible. This includes, but is not limited to examination tests, diagnostic x- rays and physiotherapy techniques which are recommended by Dr. Jeffrey Robichaud who will be rendering treatment to me.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. These include, but are not limited to, fractures, dislocations, muscle strains, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and joint separations. Some forms of cervical manipulation have been associated with injuries to the arteries of the neck leading to or contributing to serious complications- including stroke. This is a very rare occurrence, estimated at 1:3,000,000. We screen our patients for contrainidcations to cervical manipulation to the best of our ability.

I DO NOT expect Dr. Robichaud to be able to anticipate all of the risks and complications. I do expect the Doctor to exercise good judgment during the course of care performing procedures which are in my best interest in both safety and efficacy.

I have read, or have had read to me, the above explanation of chiropractic adjustments and related therapies. By signing below, I am stating I have weighed the risks involved in undergoing treatment, and have decided in favor of moving forward with care. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent to cover the entire course of care for my present condition and for future conditions for which I seek treatment.

Printed name of patient: _____
Signature of patient: _____
Signature of Patient's Representative: _____
Date: _____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to use and disclose my private health information: By signing this form I give Dr. Jeffrey Robichaud permission to use/disclose my private health information for the purposes of carrying out treatment, obtaining payment for services rendered or for routine office operations related to my care.
2. Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Dr. Jeffrey Robichaud will not be able to provide me with any treatment until such time that I agree to sign. However, in the event of an emergency where Dr. Jeffrey Robichaud is required by law to render emergency care my consent is not required.
3. Right to review notice of privacy practices: Dr. Jeffrey Robichaud has provided me the opportunity to review the privacy practices of the office regarding the disclosure of protected health information.
4. Changes to the privacy notice: Dr. Jeffrey Robichaud may change the notice of privacy practices as needed. I may obtain a copy of the revised practices by contacting the office directly.
5. Right to request restrictions on use/disclosure of information: I have the right to request that Dr. Jeffrey Robichaud restrict the use of protected health information for the purposes of treatment, payment or operations. However, I understand Dr. Jeffrey Robichaud is not required to agree to these requested restrictions. This request must be made in writing and Dr. Jeffrey Robichaud will give a written reply to my request within 48 hours of it's receipt.
6. Right to withdraw consent: I have the right to withdraw this consent at any time. I must do so in writing. My withdrawal of consent does not impact information disclosed or used prior to the request for withdrawal. If I withdraw my consent I understand Dr. Jeffrey Robichaud will no longer be able to provide me with treatment, unless required by law for emergency purposes.
7. Effective period: This consent is good from this date forward, unless I withdraw my consent in writing.
8. References to "I" and "me": References to "I" and "me" in this document include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, such as a minor child, it is because I am the legal guardian, parent of agent under an active power of attorney. I acknowledge I and legally authorized to sign this consent on behalf of the individual.

Patient name: _____
Signature: _____
Name of individual if other than the patient _____
Date:_____

DR ROBICHAUD IS IN NETWORK FOR THE FOLLOWING INSURANCE CARRIERS (If you plan on submitting your visits to one of the carriers below please find, read, sign, and date the appropriate policy waiver located on our website)	
1.	**HARVARD PILGRIM** & UNITED HEALTHCARE(OUT OF NETWORK)
2.	**BLUE CROSS BLUE SHIELD OF MASSACHUSETTS**
3.	**TUFTS HEALTH PLAN** & CIGNA(OUT OF NETWORK)
4.	**TUFTS MEDICARE PREFERRED**
5.	**MEDICARE/MEDEX**