



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 out 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, you 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.



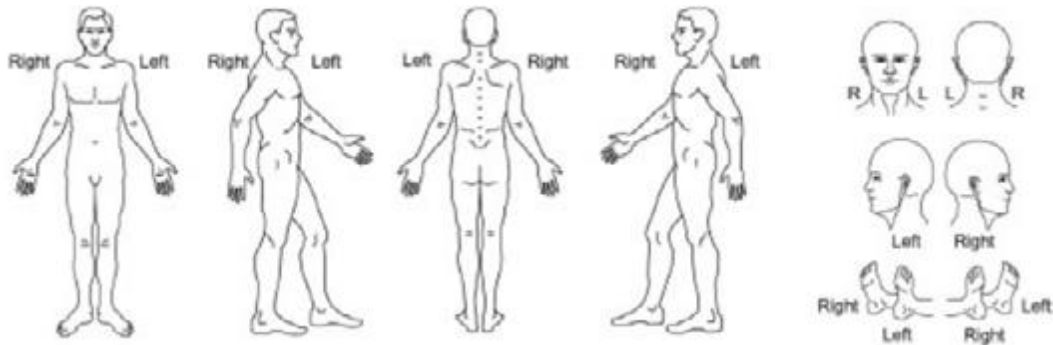
PATIENT HISTORY & ASSESSMENT

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						
<p>What are the main problem(s) you would like help with?</p> <p>When did your symptoms start?</p> <p>Please indicate where your pain/symptoms were initially located (ex. Neck, lower back)</p> <p>What would you say your symptom ratio is? % Spine % leg % arm (ex. 75% spine, 25% leg)</p>						
CIRCLE THE BEST ANSWER						
<p>1. What event(s) led to your original Symptoms?</p> <p>Accident Cancer Work Injury No obvious cause Following an operation</p> <p>Other: _____</p> <p>2. Since the time of onset, my symptoms have:</p> <p>Remained the same Became more severe Lessened in severity</p>						
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
/ /	<input type="checkbox"/> Constant <input type="checkbox"/> Comes and Goes	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night	<input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High

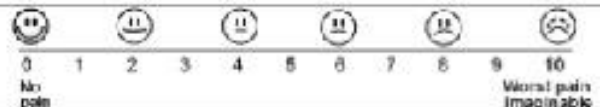
Description of Pain (Check all that apply)

- | | | | | |
|--|-------------------------------|--------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Ache | <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Sting | <input type="checkbox"/> Tingle |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Deep | <input type="checkbox"/> Superficial | <input type="checkbox"/> Swelling | <input type="checkbox"/> Throb |
| <input type="checkbox"/> Other (please describe) | | | | |

What Relieves Pain (Check all that apply)

- | | | | |
|--|-------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Cold | <input type="checkbox"/> Relaxation Technique | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Heat | <input type="checkbox"/> Repositioning | <input type="checkbox"/> Massage |
| <input type="checkbox"/> 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)

- | | | | | |
|--|--------------------------------|----------------------------------|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Sad | <input type="checkbox"/> Angry | <input type="checkbox"/> Anxious | <input type="checkbox"/> Tired | <input type="checkbox"/> Helpless |
| <input type="checkbox"/> Other (please describe) | | | | |

What Makes Pain Feel Worse

What Makes Pain Feel Better

Patient Signature/Person Completing Form

Date

Time



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 contraindications 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 am 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
2.	BLUE CROSS BLUE SHIELD OF MASSACHUSETTS
3.	TUFTS HEALTH PLAN
4.	TUFTS MEDICARE PREFERRED (WILL NEED REFERRAL FAXED OVER FROM PCP)
5.	MEDICARE/MEDEX

If your insurance carrier is one of the above, it doesn't guarantee that you have chiropractic coverage, every plan is different. If you're unsure please call your insurance carrier to determine whether your services will be covered. Also keep in mind that you may have a deductible that needs to be met before utilizing your coverage and benefits for chiropractic.

Dr Robichaud is out of network for **United Health Care** and **Cigna Health Insurance**. If you have out of network benefits and would like us to submit your visits please fill out the **Harvard Pilgrim policy waiver for United** and the **Tufts policy waiver for Cigna**.

Some plans purchased through the Massachusetts Exchange utilize a Mass Health network, Dr Robichaud is **out of network for Mass Health**. If you have purchased your plan through the exchange we strongly suggest contacting your insurance company to determine if your services with Dr Robichaud will be covered. If you are eligible for Medicare, but have decided to opt out of Medicare in favor of one of the Medicare Advantage plans you may need a PCP referral. No referral is required when Medicare is your primary insurance.