

3 Pomperaug Office Park, Suite 103

 Southbury, CT 06488-2287

 phone : (203) 263-0411

 **Erik G. LeMoullec DC, FCAMI** fax : (203) 841-1012

 Dr.Erik’s email : eriklemoullec@gmail.com

 website : www.BackToHealthSouthbury.com

|  |
| --- |
| **PATIENT INFORMATION** |
| First Name |  |
| Middle Name / Initial  |  |
| Last Name |  |
| Preferred Nickname? |  |
| Street Address |  |
| City, State |  |
| Zip Code |  |
| Cell Phone | ( ) - |
| Home Phone | ( ) - |
| Work Phone | ( ) - |
| Email |  |
| Date of Birth |  **/ /** |
| Social Security # | * **-**
 |
| How did you hear about Back to Health? |   |
| Employment Status |   | Employed |  | Un-Employed |  | Homemaker |  | Retired  |  | Student |
| Occupation |  |
| Employer |  |
| **EMERGENCY CONTACT**  |
| Name |   | Relation |   | Phone |   |
| **IF PATIENT IS A MINOR (under 18 years old)**  |
| Name of Parent / Legal Guardian |   | Relation to Patient |  |

|  |
| --- |
|  **HIPAA PRIVACY PRACTICES** |
| I have received the Notice of Privacy Practices & I have been provided with an opportunity to read it. There is a complete copy of the Privacy Act in the laminated folder below these forms (copy upon request). |
| **SIGNATURE:** TODAY’S DATE: / /  |

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| --- | --- | --- | --- |
| Patient’s Name |  | DOB |  / / |
| **PLEASE READ & SIGN THE 2 SECTIONS BELOW** |
| **TREATMENT CONSENT** |
| I hereby request and consent to the performance of Chiropractic Manipulation, Acupuncture, Active Release Technique, Graston Technique, Cold Laser and other chiropractic procedures. I understand and am informed that as in the practice of medicine, with the practice of chiropractic medicine there are some risks. These risks may include but are not limited to; fractures, strokes, disc injuries, dislocations, and sprains. I do not expect the physician to be able to explain or anticipate all risks and complications, and I choose to rely on the physician to exercise his best judgment during the course of my treatment. This concerns which treatment(s) are in my best interest, based upon the facts as they are known at that time. |
| **SIGNATURE:** TODAY’S DATE: / /  |
| **FINANCIAL RESPONSIBILITY (PLEASE CHECK ONE)** |
|  | Health Insurance Plan |   | Worker’s Compensation Case |
|   | Self-Paying Patient  | Other (explain):  |
|   | Order of Protection (Legal Case)  |
| I, the undersigned, accept financial responsibly for my services & charges at Back to Health Chiropractic & Acupuncture. If I have insurance benefits with a health insurance company, I have provided the office with a current member card to keep on file for the billing of all office visits and charges until further notice. I authorize payments be assigned directly to, Back to Health Chiropractic & Acupuncture for all benefits, if any, otherwise payable to me for services are rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I hereby authorize any holder of medical information about me to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand it is my responsibility to update this information with the office as needed. |
| **SIGNATURE:** TODAY’S DATE: / /  |

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| --- | --- | --- | --- |
| Patient’s Name |  | DOB |  / / |
| PAIN AND/OR INJURY ASSESSMENT |
| Today’s Date |  / / | Date of pain onset OR Date of your accident / injury |  / / |
| New injury or ailment? How did it occur or begin? |
| Has anything made the pain or injury worse? |
| **Please circle the letter(s) that correspond(s) with the type(s) of pain you are having:** |
| A | Ache | N | Numbness | S | Stabbing | SR | Sore  |
| B | Burning | P | Pins & Needles | SP | Sharp | D | Dull |
| O | Other : |
| **Please rate the severity of discomfort by circling the corresponding number:** |
| 0 1 2 3 4 5 6 7 8 9 10  NO PAIN MODERATE SEVERE PAIN |
| **Please mark an “X” on the picture(s) where you are having pain:** |
|  |
| **Please check a box for what amount of your day you’re experiencing this discomfort** |
|  |  | ¼ day |  | ½ day |  | ¾ day |  | Constantly |  |
| **Please check boxes for anything this discomfort interferes with:** |
|  | Work |  | Daily Routine |  | Sleep |   | Activity |
|  | Other : |
| **Please check boxes for activities/movements that aggravate or make the pain worse:** |
|  | Sitting |  | Walking |  | Bending | Other :  |
|  | Standing |  | Twisting / Turning |  | Lying Down |

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|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name |  | DOB |  / / |
| **HEALTH & HISTORY** |
| Name & Locationof Primary Care Physician: |  |
| ***Skip if not applicable* :**Currently pregnant or may be pregnant? |  yes no | If yes, # of weeks (if known) |   |
| Please tell us about your **family’s medical history****(biological parents & siblings)**… |   |
|  |
|  |
|  |
|  |
| Please tell us about your own **past and/or current medical issues**… |  |
|  |
|  |
|  |
|  |
| Please tell us about **medications or supplements** you currently take… |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **SIGNATURE:** | TODAY’S DATE: / /  |



Thank you for completing this form!

Please return it to the front desk

or bring it along to your first appointment.

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