

Northboro Chiropractic Center, Inc.

6 Maple Street, Northborough, MA 01532
Phone (508) 393-2513 Fax (508) 393-9276

Releasing Life With A Healing Touch

Confidential Patient Information

Date ____/____/____

Patient File #: _____

Patient Name: _____

CHIROPRACTIC HEALTH HISTORY

This health history form is intended to help us uncover factors that may have caused vertebral subluxations in your spine, adversely affecting your current state of health

CURRENT PHYSICAL STRESSES

Please describe your usual work position and how long you maintain it during the day? For example do you work at a computer, talk on the phone or stand at a machine for most of the day?

Does your job require regular airline travel and hotel stays? Yes / No If yes, how often? _____

While at work, do you stand or work on a concrete floor? Yes / No

How long is your commute each day? _____ How many hours do you typically work in a week? _____

How many hours per week do you watch T.V.? _____ Are you sitting or lying on a couch? Yes / No

Please describe your exercise/sports program including type and frequency:

How many hours of sleep do you typically get? _____ Do you sleep well? Yes / No

Do you ever sleep on your stomach? Yes / No How old is your mattress? _____

Do you wear orthotics (foot supports) or a heel lift? Yes / No If yes, for how many years? _____

Do you use a cervical pillow? Yes / No

Have you received Chiropractic care before? Yes/No Date of last adjustment _____

HISTORY OF PHYSICAL TRAUMA

Were you born at home or hospital? Medication used Y N C-section Y N Forceps/vacuum Y N

Significant childhood injuries (fractures, stitches, falls, sports-related, etc): Please list dates, injury and treatment:

Significant adult injuries (fractures, stitches, falls, sports-related, etc): Please list dates, injury and treatment:

Please turn over and complete the other side of this form. Thank You

Tell us about your most recent motor vehicle accident/work-related injury:

Date _____ Driver/Front passenger/Rear passenger Seatbelt: **Y N** Airbag discharged **Y N**

Injuries: _____

Care received: _____

Previous motor vehicle accident/work-related injury:

Date _____ Driver/Front passenger/Rear passenger Seatbelt: **Y N** Airbag discharges **Y N**

Injuries: _____

Care received: _____

HISTORY OF CHEMICAL STRESSES

How many fast food meals do you eat per week? _____

How many alcoholic beverages do you drink per week? _____

Do you smoke tobacco products? Yes / No How many per day? _____ Exposed to second hand smoke? Yes / No

How many glasses of water do you drink per day? _____

How many caffeinated beverages (coffee, tea or cola) do you drink per day? _____

Do you consume artificial sweeteners? Yes / No If yes, how many packets per day? _____

Are you currently on prescription or over the counter drugs? Yes / No

If yes, which ones? daily dosage? how long? _____

Describe any nutritional supplements that you are taking: _____

How would you rate your current physical health? _____Excellent _____Good _____Fair _____Poor

HISTORY OF EMOTIONAL STRESSES

Please rate your level of stress (1-5): 0 if not applicable / 1 is mild stress while 5 is severe stress:

__ Childhood

__ Friends

__ Parents divorce

__ Commuting

__ Family

__ Chronic illness or disability

__ Finances

__ Verbal Abuse

__ Loss of a love one

__ School

__ Addictions

__ Spouse/significant other

__ Work

__ New job

__ Divorce/separation

How would you rate your emotional/mental health? _____Excellent _____Good _____Fair _____Poor

Please describe the REASON FOR YOUR VISIT: _____

What are some activities that you can no longer do because of your current health condition? _____

What are your top 3 health goals: _____

Patient Signature _____ Date _____

Please return this important information to the receptionist.

*Northboro Chiropractic Center
6 Maple Street
Northboro MA 01532*

Patient Name: _____

Date: _____

Below is a list of health issues that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING HEALTH ISSUES YOU HAVE EVER HAD:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Eczema |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST YEAR:

NERVOUS SYSTEM CODE

- Nervousness/anxiety
- Irritability/impatience
- Depression
- Attention deficit
- Stress
- Dizziness
- Forgetfulness
- Confusion
- Fainting
- Convulsions
- Cold Extremities

GENERAL

- Headaches
- Migraines
- Loss of Sleep
- Allergies
- Fatigue
- Fibromyalgia

GENITO-URINARY

- Bladder Trouble
- Discolored Urine
- Painful Urination
- Excessive Urination

EENT

- Vision Problems
- Sinus Infections
- Earaches
- Hearing Difficulty

GASTROINTESTINAL

- Poor Appetite
- Excessive Appetite
- Excessive Thirst
- Excess Weight
- Significant Weight Loss
- Frequent Nausea
- Gas or Bloating After Meals
- Heartburn
- Vomiting
- Diarrhea
- Constipation
- Abdominal Cramps
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Diagnosed IBS, Crohn's, Diverticulitis, Colitis
- Black/Bloody Stool

CARDIOVASCULAR/RESPIRATORY

- Chest Pain
- Shortness of Breath & Asthma
- High Blood Pressure
- Irregular Heartbeat
- Stroke
- High Cholesterol

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate Sexual Dysfunction
- Infertility Problems
- Other: _____

FEMALES ONLY:

When was your last period?

Are you pregnant?

- Yes No

FAMILY HISTORY

The following family members have the same or similar problem(s) as I do:

- Mother
- Father
- Sister
- Brother
- Spouse
- Child

SYMPTOM DRAWING

Patient Name: _____

Date: _____

Please read carefully:

Mark the areas on your body where you feel your symptoms. Use the appropriate symbol(s) listed below.

Dull Pain: dp dp dp

Burning: bu bu bu

Sharp Pain: sp sp sp

Stabbing: st st st

Aching: ac ac ac

Tingling: ti ti ti

Throbbing: th th th

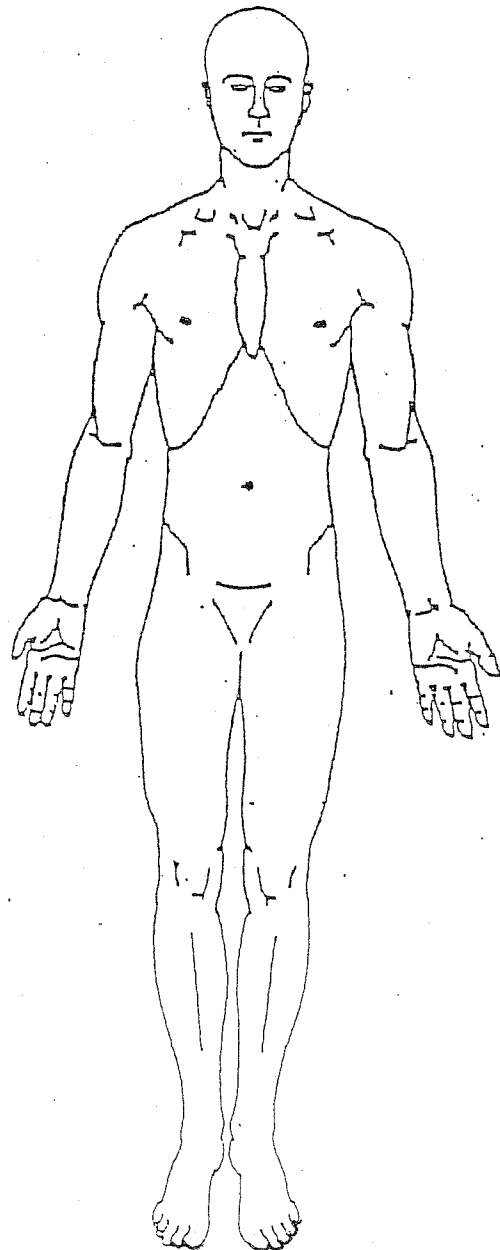
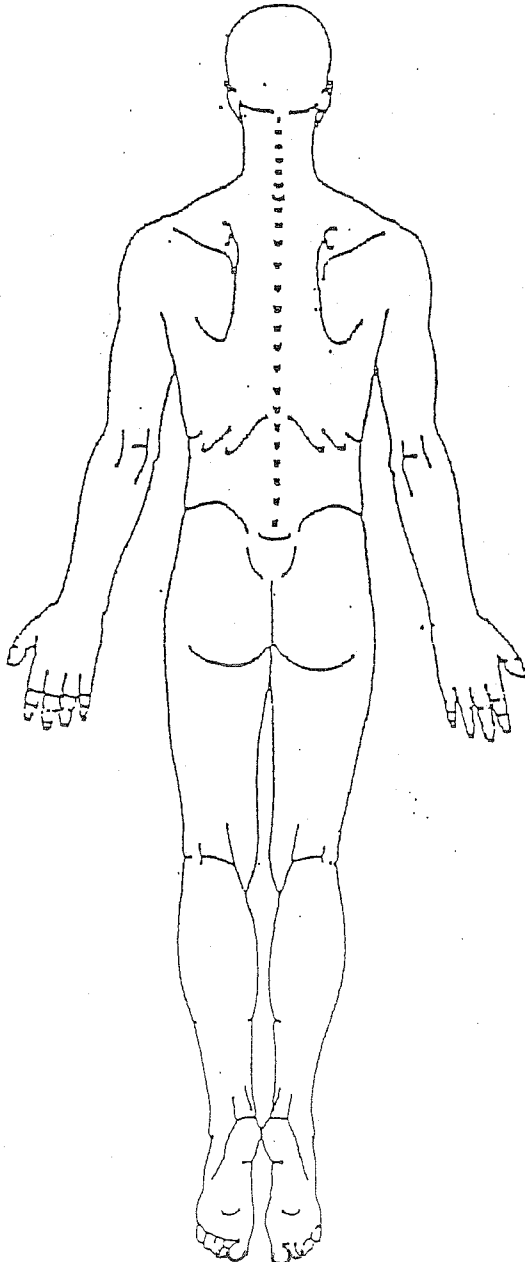
Numb: nu nu nu

Sore: so so so

Stiff: stf stf stf

SEVERITY SCALE:

0 being normal and 10 being severe. Indicate your degree of severity



HIPPA Notice of Privacy Practice

Northboro Chiropractic Center
6 Maple Street
Northboro, MA 01532
(508) 393-2513

APPOINTMENT REMINDERS & HEALTH CARE INFORMATION AUTHORIZATION

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders / information and understand that ...

I may be contacted by: telephone at home or work, mobile phone or postcard.
Messages may be left: on answering machine / voicemail at home, work and on my mobile phone. Or with individuals answering my telephone at home or at work.

(Please place a line through any method that you refuse to be contacted by and initial.)

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone that has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we received the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (164.524).

I authorize the disclosure of my health information as described above and I acknowledge that I have received a copy of the Northboro Chiropractic Center Notice of Privacy Practices for Protected Health Information.

Patient Name

Signature

Date

TERMS OF ACCEPTANCE AND CONSENT TO CHIROPRACTIC SERVICES

When a person seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective. It is important that every person who begins care understands both the objective and the method(s) that will be used to attain it.

VERTERBRAL SUBLUXATIONS: A misalignment or loss of function of one or more of the 24 vertebrae in the spinal column which causes an interference to the transmission of nerve impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

THE CHIROPRACTIC OBJECTIVE: To analyze the spine, locate and correct vertebral subluxations so that the inborn wisdom of the body can be more fully expressed.

THE CHIROPRACTIC ADJUSTMENT: The specific application of gentle force to the spinal column in which facilitates the body's correction of vertebral subluxation.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease and infirmity. Chiropractic recognizes that true health can only come from within.

DIS-EASE: Lack of ease, i.e., lack of health. An expression of the inability of your body to adapt to chemical, emotional or physical stresses.

I, _____ authorize the performance upon myself of examinations, and/or treatments performed by or under the direction of doctors, associates or assistants employed by the Northboro Chiropractic Center.

I also consent to the performance of other diagnostic and therapeutic procedures in addition to, or different from those stated above, whether or not arising from presently unforeseen conditions that the doctors, associates or assistants employed by the Northboro Chiropractic Center may consider necessary or advisable in the course of my health care.

The nature and purpose of the procedures, the possible alternatives, and the risks involved, the possible consequences, and the possibility of complications have been explained to me by the doctors, associates or assistants employed by the Northboro Chiropractic Center.

I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure has been given by the doctors, associates or assistants employed by the Northboro Chiropractic Center.

Date: _____ Signed: _____

Northboro Chiropractic Center, Inc.

6 Maple Street, Northborough, MA 01532
Phone 508.393.2513 Fax 508.393.9276

Confidential Patient Information

Date ___/___/___

Patient File #: _____

First Name _____ M.I. _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Date of Birth ___/___/___

Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____ Ext. _____

E-Mail _____ Cell Phone _____

Financial Policy

We are committed to providing you and your family with the best chiropractic care possible in a caring environment. Our financial policies are designed to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you participate in one of our financial plans which include annual, quarterly, and monthly payment options. Our care plans are designed to be the most cost effective way to keep you and your family as healthy as possible. For many of you, our care plan fees are very close to your co-payment amount. *Details of these plans will be discussed in your Care Plan report.*

Harvard Pilgrim, GIC (check box)

Our office is happy to file insurance for you once you commit to a care plan. Although both our staff and you have verified your chiropractic benefit coverage, it is important to know that all insurance companies state the disclaimer that:

"VERIFICATION IS NOT A GUARANTEE OF PAYMENT." You are ultimately responsible for any co-payments, deductibles, and portion of your care not covered by your insurance plan. Health insurance does not cover wellness care. If any submitted claims are rejected or not paid by your insurance company within 60 days, our office will bill you for the services. We strongly advise you to maintain contact with your insurer in order to confirm coverage and reimbursement.

Other Health Insurances or Flex Spending Accounts / MSA (check box)

If you have other insurance or flexible spending/medical savings accounts that contribute to chiropractic care, we will provide you with the necessary statements to obtain reimbursement after you participate in one of our payments plans. It is important to know that all insurance companies state the disclaimer that: **"VERIFICATION IS NOT A GUARANTEE OF PAYMENT."**

Medicare

We are not providers for Medicare, but we do offer a discounted senior citizen fee of \$25.00 per adjustment.

Thank you for choosing our office for the chiropractic needs of you and your family.

Patient Signature: _____

Date: _____