

NEW ENGLAND CHIROPRACTIC

"Your Family Wellness Team"

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WELCOME

The doctors and staff of New England Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Will you be using insurance in our office or have you heard about our family plans? (please circle)

PATIENT IDENTIFICATION

Name _____ Name or Nickname I prefer to be called _____
in this office _____
Address _____ Telephone (Home) _____
_____ (Work) _____ (Cell) _____
Ok to call there? Yes () No ()
E-mail Address _____ Employer _____
SSN _____ Occupation _____
Male () Female () Date of Birth _____ Age _____
Marital Status M() S() W() D()
Contact in case of emergency, Name: _____
Telephone # _____
Name of Parent of Minor Patient (If applicable) _____
Name & number of Primary Care Physician? _____
By whom were you referred to our office? _____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of New England Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctors can determine whether to accept me as a patient.

Date

Signature

PATIENT NAME: _____

DATE: _____

New England Chiropractic

Health Information

What is your major complaint? _____

How long have you had this condition? _____

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

If yes, when? _____

What activities aggravate your condition? _____

What makes it better? _____

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

Is this condition interfering with your: Work Sleep Daily Routine

Other _____

How long has it been since you really felt good? _____

Has there been any medical diagnosis of your complaint? Yes No

If yes, list the doctor's name and diagnosis _____

List and date surgical operations: _____

List any Prescription Drugs, Over the Counter Drugs, Vitamins and Natural Supplements you are now taking: _____

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Have you been in an auto accident? Never Past year Past 5 yrs Over 5 yrs

Describe _____

Have you had any other personal injury or accident? None Past year Past 5 yrs

Over 5 yrs

Describe _____

Date of last complete, thorough, physical exam _____

By whom? _____

Have you ever been to a chiropractor before? Yes No

If yes, who? _____ When was last visit? _____

What was the problem? _____

Was level of relief sought/achieved? _____

Have you had previous healthcare for this problem? Yes No

If yes, where and when? _____

Were x-rays taken? Yes No

REASON FOR CONSULTING THE OFFICE

- I have a specific problem and require help only with this problem.
- After my specific problem has been relieved, I am interested in strategies to insure the problem does not return.
- After my specific problem has been resolved and I understand methods to insure it does not return, I am interested in strategies to improve my general health.
- I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well or even better.

PATIENT NAME _____

DATE _____

NEW ENGLAND CHIROPRACTIC

History Form

Please mark column (P) if you are experiencing these presently or (H) if you have a history of these symptoms.

	P	H		P	H
Visual disturbances			Numbness on one side of face or body		
Pass out easily			Rapid eye movement or double vision		
Faint/loss of consciousness			Headaches for hours or days		
Double vision			Change in bowel or bladder habits		
Lost sight in one eye			Sore that does not heal		
Any slurred speech			Unusual bleeding or discharge		
Difficulty with speech			Thickening in your breasts or elsewhere		
Difficulty in arranging words properly			Indigestion or difficulty swallowing		
Difficulty walking			Change in any wart or mole		
Difficulty with coordination			Nagging cough or hoarseness		
Falling to one side			Pain in neck, jaw or face		
Chest pain			Drooping eyelid or change in your pupils		
Night sweats			Ringling in your ears		
Visual disturbances			Any loss of bladder or bowel control		
Blood in stools or urine			Pain waking you from a sound sleep		

Do you take birth control pills? Yes ___ No ___

Do you have a history of stroke in your family? Yes ___ No ___

Do you have a history of atherosclerosis? Yes ___ No ___

Have you ever had cancer? Yes ___ No ___

Are you losing weight now without trying? Yes ___ No ___

Are you seeing any other doctor now for any reason? Yes ___ No ___

Note: _____

What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____

ALCOHOL _____ Yes or _____ No, If Yes, how much _____

PATIENT NAME: _____

DATE: _____

Family History

Did you, your mother or your father have any of the following?
Put an **M** for mother, **F** for father, and **Y** for you.

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer or Stomach Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis-Rheumatism |
| <input type="checkbox"/> Seizure-Convulsions | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | |

Comments: _____

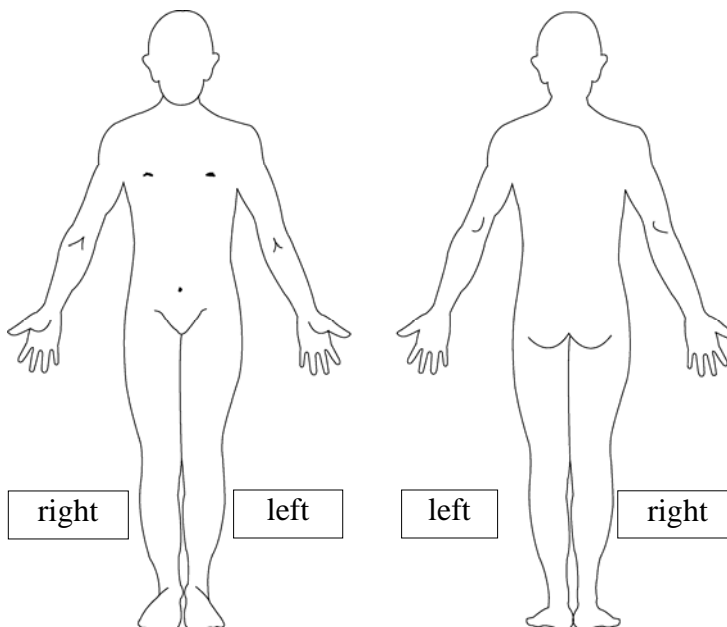
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
 0 10
 no pain severe pain

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
 0 10
 no pain severe pain

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
 0 10
 no pain severe pain

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1. You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required by the law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. If you would like further information or have a complaint about our privacy policies and practices please contact: Dr. Lain or Dr. Kelly.

2. It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

3. It is our desire for our staff to use your name, address, E-mail and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. We may also call to remind you of scheduled appointments, re-evaluations, appointment related issues, or other special events (birthdays, functions, etc.)

The use of this information and format of "open adjusting" is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from the doctors or on your relationship with our staff.

4. Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.