

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Best Phone Number: _____ Home Work Cell (circle one)

Alternate Number: _____ Home Work Cell **Date:** _____

Age _____ Birthdate _____ E-Mail _____

Marital Status: M S W D Occupation _____

Spouse's Name _____ **How did you hear about our office?** _____

HEALTH INFORMATION:

Have you had previous chiropractic care? _____

What is your major complaint? _____

Other complaints _____

Onset of complaints/condition _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition interfering with your: Work Sleep Daily Routine Other

Other doctors who treated this condition _____

List surgical operations and years _____

Drugs you now take: Pain Killers Muscle Relaxers Insulin Other _____

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

Describe _____

Have you had any other personal injury, job related injury or accident?

Past year Past 5 years Over 5 years None

Describe _____

Have you ever suffered from:

- Dizziness
- Backaches
- Heart trouble
- Diabetes
- Arthritis
- Headaches
- Asthma
- Neuritis
- Digestive Disorders
- Nervousness
- Neck Pain

Describe your primary area of pain:

Rate your primary complaint on the pain scale:

On a pain scale of 1-10 (with 0 = no pain and 10 being unbearable pain)

0 / / / / / / / / / / / 10
1 2 3 4 5 6 7 8 9 10

What is the estimated percentage of time you experience the pain?

0% / / 100%
(intermittent) 25%(occasional) 50% (frequent) 75% (constant)

Describe your second area of pain:

On a pain scale of 1-10 (with 0 = no pain and 10 being unbearable pain)

0 / / / / / / / / / / / 10
1 2 3 4 5 6 7 8 9 10

What is the estimated percentage of time you experience the pain?

0% / / 100%
(intermittent) 25%(occasional) 50% (frequent) 75% (constant)

Describe your third area of pain:

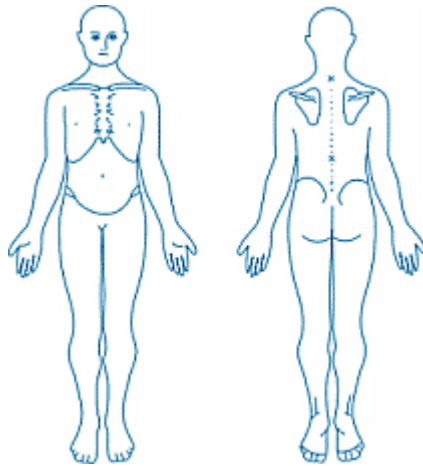
On a pain scale of 1-10 (with 0 = no pain and 10 being unbearable pain)

0 / / / / / / / / / / / 10
1 2 3 4 5 6 7 8 9 10

What is the estimated percentage of time you experience the pain?

0% / / 100%
(intermittent) 25%(occasional) 50% (frequent) 75% (constant)

Please mark your areas of pain on the figures below.



INSURANCE INFORMATION

Do you have Health Insurance? Yes No

Are you covered by Medicare? Yes No

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ S.S. # _____

ASSIGNMENT OF BENEFITS BY A PATIENT TO A PHYSICIAN

I hereby assign to my physician all benefits for such services to which I am entitled under my Personal Injury Protection and/or Medical Payments coverage, and request my insurance company to pay any such benefits directly to my physician upon submission of any claim

Date _____ Signed: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Waltham Chiropractic's *Notice of Privacy Practices for Protected Health Information*.

Date _____ Signed _____

INFORMED CONSENT

When a patient seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they both be seeking the same goals. The practice of chiropractic in this office consists of analysis and adjustment of the spine for the purpose of locating and correcting **vertebral subluxations**. (spinal misalignments causing nerve interference). We also strive to educate and encourage our patients/practice members to become aware of and responsible to their well being.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of “treating” or “curing” diseases or conditions.

Physicians, chiropractors, osteopaths and physiotherapists using manual manipulation are required to advise their patients that there have been rare incidents of injury to the vertebral artery during the course of treatment. There have caused strokes or stroke-like occurrences which are usually of a temporary nature. The chances of this happening are approximately 1 in 3 million treatments. There have also been rare incidents of rib bruising or swelling of aggravation of symptoms. Appropriate tests will be performed on you to minimize your risks.

It is important that you understand that chiropractic care involves a “hands on” approach. During the delivery of a chiropractic adjustment or diagnostic procedure, there may be physical contact made in possibly sensitive areas. By signing below you are acknowledging that you have been informed of and consent to the type of care you will receive and that you have been made aware of any risks inherent in that care. You also acknowledge that you have been made aware of other treatment options. If a change in approach, additional testing, referrals to other providers or a need to apply care requiring a different touch is required it will be discussed with you prior to it being administered. If at any time you are in any way uncomfortable with any aspect of the care that you are receiving, please do not hesitate to let us know.

Our practice is based on the simple truth that if we satisfy and delight our patients, they will get well faster and be more likely to tell others about their chiropractic experience. Since chiropractic results vary, we can't guarantee results, but we can promise your satisfaction. Within 3 days of beginning care, if you are not completely happy with your decision to begin chiropractic care in this office, we will happily refund the money you've paid us.

I/We understand and consent to care at Waltham Chiropractic for myself/my family, as outlined in this “Informed Consent”.

Name (print): _____

Signed: _____

Date: _____

*Waltham Chiropractic
425 River St.
Waltham, MA 02453*

Cancellation Fees & Agreement

The staff at Waltham Chiropractic takes the time to treat all patients as efficiently as possible. In order to do that, we schedule appointments so that patients can be seen and treated in a timely manner. In order to maintain a proper schedule, we must now enforce a cancellation policy to all patients.

If you cancel an appointment less than 24 hours prior to it, or you do not show up for the appointment, you will be charged a \$15 fee.

Please note scheduling an appointment is required. If you walk in for an appointment we cannot guarantee you will be seen immediately.

I, _____, understand that I will be charged a \$15 fee for any scheduled appointment that I cancel with less than 24 hours notice, or do not show up for.

SIGNED

DATE