

Welcome to Chiropractic

Please Print Clearly and fill in completely.
(Adult)

Print Name _____ Email _____

Street Address _____ Date of Birth _____

City _____ State _____ Zip _____ Male Female

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Credit Card _____ Exp. Date _____

Who may we thank for referring you to our office? _____

Please Check Sex: Male Female Right handed Left handed Married Single

Health History:

Reason for seeking chiropractic care: _____

Describe any health problems, including how long you've had them: _____

Have you seen any other doctor for this problem? Yes No Name: _____

Were you referred by any doctor? Yes No Name: _____

Name, Phone# & Address of PCP: _____

List any current Medications: _____

Family History:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please feel free to mention below any health concerns you may have about your:

Spouse: _____

Children: _____

Parents: _____

Siblings: _____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name _____

Date of last chiropractic visit _____ Reason for care _____

Date of last chiropractic x-rays _____ How long were you under care? _____

Are other family members under chiropractic care? - Yes No Who? _____

Current Complaint

I would describe the pain as: sharp dull comes and goes travels constant

Since the problem started, it is: about the same getting better getting worse

What makes it worse? _____

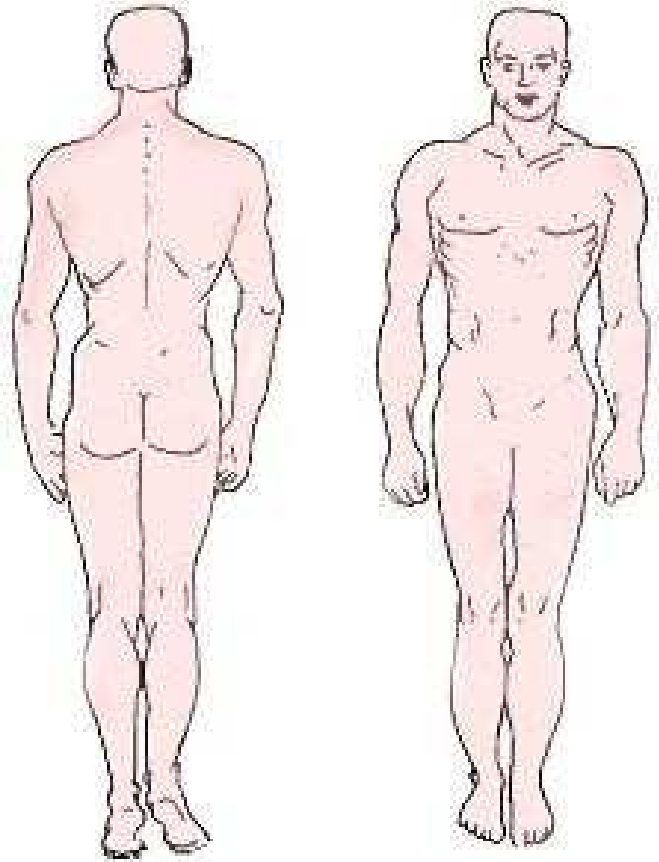
It interferes with: work sleep walking sitting hobbies leisure

Please Fill in Below

If you have had the following, or if you suffer from the following, **Please Check** ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Female problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

Childhood History (Prior to age 18)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer these questions to the best of your ability.

- | | | |
|---|------------------------------|-----------------------------|
| Did you have any childhood illnesses? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Did you have any serious falls as a child? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Did you play any youth sports? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Did you have any surgery? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Prolonged use of medicines? I.e.: Antibiotics, inhalers, etc. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any car accidents? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any major falls? I.e.: Tree, seesaw, crib etc. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Were you vaccinated? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Were you under regular Chiropractic care? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Adult History (age 18 to present)

- Do / did you smoke? Yes No If yes, how long and how much? _____
- Do / did you drink alcohol? Yes No
- Do / did you play adult sports? Yes No
- Did you have any surgery? Yes No
- Any car accidents? Yes No
- Prolonged use of medicines? I.e. Antibiotics, inhalers, etc. Yes No
- On a scale of 1=none to 10=severe, rate your stress at home _____ at work _____
- On a scale of Poor, Good, Excellent: Describe your:
Diet _____ Exercise _____ Sleep _____ General Health _____
- Have you ever:
- Bought bottled water? Yes No
- Belonged to a health club? Yes No
- Consumed vitamins or supplements? Yes No

Wellness Commitment

At Billerica Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10% ___ 20% ___ 30% ___ 40% ___ 50% ___ 60% ___ 70% ___ 80% ___ 90% ___ 100%

Insurance Information (if applicable)

Name of Insured: _____ Date of Birth: _____
Insurance Company _____ Phone # _____
ID# _____ Policy # _____

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 collections from the insurance company and that any amount authorized to be paid to Billerica Chiropractic office will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED 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 Name _____ Signature _____ Date _____
Guardian's Name _____ Signature _____ Date _____

Billerica Chiropractic

Consent to Initiate Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal, mental and social well-being, not merely the absence of infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date