Welcome to Billerica Chiropractic

NEW PATIENT INTAKE FORM

Print Name _____ **Today's Date** _____

Address _____**City**_____ **State** _____**Zip** _____

Email Address _____ **Male** **Female**

Social Security # _____ **Date of Birth** _____**Age** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Occupation _____ **Employer** _____

Single _____ **Married** ____ **Spouse's Name** _____

If Minor: Mother's name _____ **Cell Phone #** _____

Father's name _____ **Cell Phone #** _____

Emergency Contact Name _____ **Phone #** _____

Have you had prior chiropractic care? No __ **Yes** __ **If yes, where:** _____ **When** _____

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

Health History:

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

	Headaches		Pins and needes in legs		Fainting		Neck pain
	Pins and needles in arms		Loss of smell		Back pain		Loss of balance
	Dizziness		Buzzing in ears		Ringing in ears		Nervousness
	Numbness in fingers		Numbness in toes		Loss of taste		Stomach upset
	Fatigue		Depression		Irritability		Tension
	Sleeping problems		Neck stiff		Cold hands		Cold feet
	Diarrhea		Constipation		Fever		Hot flashes
	Cold sweats		Lights bother eyes		Problem urinating		Heartburn
	Mood swings		Menstrual pain		Menstrual irregularity		Ulcers

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: _____

Name, Phone# & Address of PCP: _____

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** _____

(If minor) I hereby authorize Billerica Chiropractic Office to evaluate and administer chiropractic care as deemed necessary to my child, _____. **Parent Signature** _____ **Date** _____

Billerica Chiropractic Office

Electronic Health Records Intake Form

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Current Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Heavy Tobacco Smoker / Light Tobacco Smoker Start Date: _____ # Years Smoked: _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage	Frequency	Start Date

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____ Heart Rate: _____

☐ **I choose to decline receipt of my clinical summary after every visit**
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date:_____

Functional Rating Index

For use with Neck and/or Back Problems only.
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ Total Score _____
PRINTED

_____ _____
Signature Date

BILLERICA CHIROPRACTIC OFFICE, P.C.

AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all question presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These tests and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination: less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENT: We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related maters and thank you notices for referrals using your first name in the following manner: phone (work, home, or mobile), email and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device, voicemail, or with the person answering your phone (work, home, or mobile). Also, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

_____ _____
Patient name printed Date

_____ _____
Patient signature Authorized provider rep.

_____ _____
Personal Representative Printed Personal Rep. Signature

_____
Description of personal representative's authority to act for the patient.