BOSTON
Copley Square
Chiropractic Office

To The New Patient

Outline of Procedure for New Patients

1. Step One: All new patients are requested to fill out a personal health/history questionnaire.

2. Step Two: Your first consultation with the doctor to discuss your health problems.

3. Step Three: Diagnostic, chiropractic, orthopedic, and neurological examination procedures to determine if chiropractic care is appropriate for your condition.

4. Step Four: The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary.

5. Step Five: If your case requires immediate attention, emergency first aid will be administered.

6. Step Six: You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.

7. Step Seven: After you return and receive your report of findings your recommended treatment program will be explained to you.

8. Step Eight: Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

Personal History

Date: _____ Social Security #: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Business/Employer: _____ Type of Work: _____

Circle One: Married Single Widowed Divorced Separated # of Children ___

Name and number of Emergency Contact: _____

Referred to this office by: _____

Who is responsible for your bill: ☐ Self ☐ Spouse ☐ Workman's Comp.

☐ Medicaid ☐ Medicare ☐ Auto Insurance ☐ Major Medical Insurance

☐ Other _____

Current Health Condition

Purpose of this appointment: _____

_____

Other doctors seen for this condition: _____

When did this condition begin? _____

☐ Job related ☐ Auto related

Drugs you now take: ☐ Nerve pills ☐ Pain killers/Muscle relaxers

☐ Blood pressure medicine ☐ Insulin ☐ Other _____

Past Health History

Please check or describe:

Major Surgery/Operations ☐ Appendectomy ☐ Tonsillectomy ☐ Gall bladder

☐ Hernia ☐ Broken bones ☐ Other _____

Major accidents or falls: _____

_____

Hospitalization (other than above): _____

_____

Previous Chiropractic care: ☐ None ☐ Doctor's Name and approximate date of last visit:

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and possibility of being accepted for care.

Check any of the following diseases you have had:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

Check any of the following you have or have had in the past 6 months:

Muscolo-Skeletal Code

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Difficult Chewing/Clicking jaw

Nervous System Code

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

General Code

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Headache

Gastro-Intestinal Code

- ☐ Poor/Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder problems
- ☐ Weight trouble
- ☐ Abdominal cramps
- ☐ Gas/bloating after meals
- ☐ Heartburn
- ☐ Black/bloody stool
- ☐ Colitis

Genito-Urinary Code

- ☐ Bladder trouble
- ☐ Painful/excessive urination
- ☐ Discolored urine

C-V-R Code

- ☐ Chest pain
- ☐ Short breath
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems/congestion
- ☐ Varicose veins
- ☐ Ankle swelling

EENT Code

- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Stuffed nose

Male/Female Code

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal pain/infections
- ☐ Breast pain/lumps
- ☐ Prostate/sexual disfunction

Do not write below this line

Diagnosis:

Patient accepted: ☐ Yes ☐ No Doctor's Signature _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Temporary Relief). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your Chiropractic Care program.

Please check the type of care desired so that we may be guided by your wishes when possible:

☐ Temporary relief ☐ Corrective Care
☐ Comprehensive Care ☐ I prefer the doctor select the type of care he/she feels is best for me.

Insurance Information:

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Do you have health insurance? ☐ Yes ☐ No If yes, Policy # _____

Name of Company Agent's Name _____

Are you covered by Medicare? ☐ Yes ☐ No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrrangement 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 directly to this chiropractic office will be credited to my account on 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's Signature _____ Date _____

Guardian or Spouse's Signature _____

Doctor's Signature _____

Family Health Information

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better understanding of your total health picture.

Name	Relation	Past and Present Health Problems

The purpose of
BOSTON COPLEY SQUARE CHIROPRACTIC OFFICE
is to support individuals
in achieving their optimum health
and to educate them so that they may
understand health and Chiropractic
and in turn educate others.