Patient Care Guidelines

Patient Name:_____

Today's Date: _____Date of Birth:_____

CONFIDENTIAL

Welcome!

Please read and sign the following guidelines for care in our office. If you have any questions/concerns, please be sure to ask. We want to make sure that you have the best possible experience in our office.

1. Please fill out ALL forms completely (including electronic forms), and provide a copy of your most up to date insurance card to the front desk.
2. Be sure to sign in at the front desk at every visit, and let us know of any changes to your personal or health information.
3. Please put your phone on silent or vibrate upon entering the office. If you are on the phone when you are about to be brought in for treatment, the next person will be taken instead so as not to hold up other patients.
4. With the exception of the first 2 or 3 visits, treatments are pre-scheduled for the upcoming 2-4 weeks, depending on your treatment plan. We understand that this can be difficult, and we will make every accommodation that we can for varying schedules.
5. KNOW WHEN YOUR NEXT APPOINTMENT IS SCHEDULED! All missed appointments, or cancellations with less than 12 hours notice will be charged a $25 fee. Multiple missed appointments will result in a $50 fee. This fee will be waived if the appointment is made up within 7 days of the originally scheduled date. A "make-up" appointment is in addition to those that are already scheduled.
6. We strive to give every patient the time needed to provide proper care, even if it means we run a few minutes behind for a short while. It doesn't happen a lot, but we do appreciate your patience when it does.

A NOTE ABOUT INSURANCE

Most insurances do have coverage for Chiropractic care. However, every insurance is different. Most insurances will not cover, or allow us to provide, treatment on the day of the initial visit. Some insurance companies will ONLY cover a Chiropractic adjustment. All other services must be paid for out of pocket. This may include examinations, re-evaluations and ANY OTHER THERAPY provided in this office. You may even have additional paperwork that needs to be filled out in order to have your care covered.
That being said, if you have insurance, we MUST bill them for any services that we render. If these services are not covered, we are required to collect that additional fee from the patient. If you have concerns about specific procedure being covered, please contact your plan administrator.

Patient's Signature:_____ Date:__/__/____

Haverhill Family Chiropractic
606 Broadway, Haverhill, MA 01832
T: 978.521.2225 F: 978.521.2678

Haverhill Family Chiropractic

New Patient Questionnaire

HIPAA
Protected Health Information
Authorized Access Only

Please fill out this form to the best of your ability. The information that you provide will help us to evaluate your condition.

Patient Information

HAVE YOU SEEN A CHIROPRACTOR BEFORE? ☐ Yes ☐ No

Name: _____
Last First

Birth Date: _____ / _____ / _____ Gender: ☐ Male ☐ Female Height: _____ ft _____ In Weight: _____ lbs

Address: _____
Street Apartment #

_____
City State Zip Code

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____

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

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Primary Care Physician: _____ Phone: _____

REFERRED TO THIS OFFICE BY: _____

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 / I Decline to Answer

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

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

Signed _____ Date _____

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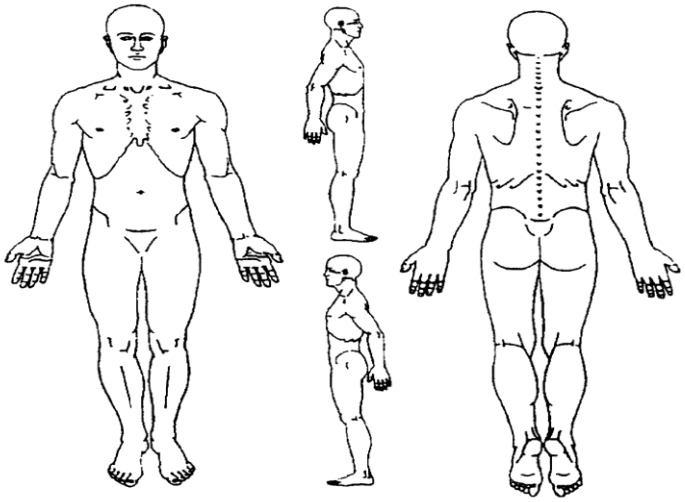
1. Please state your major complaint/purpose for this appointment: _____

_____

Please mark the location of your pain with an X on the diagram below.



On a scale of 1 to 10, how intense are your symptoms? (Please circle a number)

Very Mild 1 2 3 4 5 6 7 8 9 10 Unbearable

2. Describe your pain: ☐ Ache ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Dull ☐ Deep ☐ Numbness ☐ Sore ☐ Other

3. When did this problem begin? _____

4. What caused the pain to begin? _____

5. Is this problem accident-related? ☐ Yes ☐ No If so, what type of accident? _____

6. Who else have you consulted for this problem?

_____

Name of Practitioner Specialty

7. Have there been any recent changes in your weight? ☐ Yes ☐ No

If so, explain _____

8. Have you noticed any changes in bowel/bladder function? ☐ Yes ☐ No

If so, explain _____

9. Are your symptoms? ☐ Getting better ☐ Staying the same ☐ Getting worse

10. Date of last complete physical: _____ / _____ / _____

11. Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

_____ packs per day How many years have you been smoking? _____

12. Do you drink alcoholic beverages? ☐ Yes ☐ No _____drinks per week

13. FOR WOMEN: Are you pregnant? ☐ Yes ☐ No If so, how many weeks? _____

Are you currently breastfeeding? ☐ Yes ☐ No Date of last menstrual period: _____ / _____ / _____

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Personal History

Please check any of the following disorders that you have, or have had in the past:

☐ Allergies	☐ Chronic Diarrhea	☐ Heart Disease	☐ Palpitations	☐ Stroke
☐ Anemia	☐ Constipation	☐ Hemorrhoids	☐ Pertussis	☐ Thyroid Disorder
☐ Arthritis	☐ Diabetes	☐ Hernia	☐ Pneumonia	☐ Tuberculosis
☐ Blood in Urine	☐ Difficulty Breathing	☐ Hypertension	☐ Polio	☐ Ulcer
☐ Bloody Stool	☐ Difficulty Swallowing	☐ Liver Disease	☐ Renal Disease	☐ Urinary Frequency
☐ Cancer	☐ Edema	☐ Measles	☐ Rheumatic Fever	☐ Urinary Tract Infection
☐ Chest Pain	☐ Epilepsy	☐ Mental Disorder	☐ STD	☐ Vertigo/Dizziness
☐ Chicken Pox	☐ Gallbladder Disease	☐ Mumps	☐ Sinusitis	☐ Visual Dysfunction
☐ Chronic Cough	☐ Hearing Difficulty	☐ Painful Urination	☐ Small Pox	

Please explain any checked items: _____

Please describe any other conditions you have/had: _____

Are you currently taking any medications on a regular basis? (If you have a list available, we will be happy to make a copy)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Additional Comments

Family History

Check if Unknown ☐	Diabetes	Heart	Kidney	Cancer	Back
Father – Living __Y __N	Y N	Y N	Y N	Y N	Y N
Mother – Living __Y __N	Y N	Y N	Y N	Y N	Y N
Brother(s) - # of _____	Y N	Y N	Y N	Y N	Y N
Sister(s) - # of _____	Y N	Y N	Y N	Y N	Y N

I, _____ certify that the information contained on this intake form is true and complete to the
Patient Name
best of my knowledge.

Patient's Signature _____ Date:_____

Doctor's Signature _____

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