BAY STATE CHIROPRACTIC

PATIENT BASIC INFORMATION

Last Name: First Name: Initial:

Address: City, State, Zip

Home Phone #: Work Phone #:

E-Mail address:

Social Security #: Date of Birth:

Employer: Address:

Name of Spouse:

Name and Phone # of nearest relative in case of emergency

Health Insurance Information:

Name of Insurance Company:

_____

Subscriber's Name:_____ Relationship:

Subscriber's Place of Business: _____

Subscribers Date of Birth: _____

INSURANCE CO-PAYMENTS AND SELF PAYMENTS ARE EXPECTED AT THE TIME OF THE VISIT

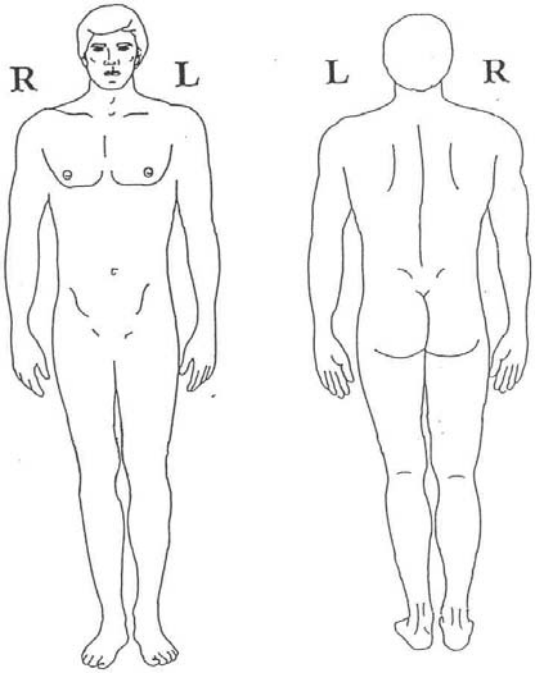
I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT BAY STATE CHIROPRACTIC WILL PREPARE THE NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY, AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS CHIROPRACTIC OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED FOR ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I HEREBY GIVE PERMISSION FOR BAY STATE CHIROPRACTIC TO SEND INFORMATION TO ANYONE DR. DIENER DEEMS NECESSARY WHO MAY BE INVOLVED IN MY HEALTH OR COLLABORATIVE CARE.

PATIENT'S SIGNATURE _____Date_____

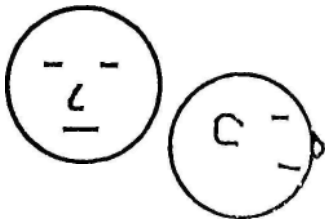
Current Complaint

Use the symbols shown on the right to mark the location and the type of pain or sensations you are feeling.



>>> Aching Pain
XXX Burning Pain
= = = Numbness
OOO Pins&Needles
////// Stabbing Pain

For Face or Head Pain



The pain / problem began on or about: _____

The cause of your problem is….❑ *Unknown* **OR (finish the sentence)** "The problem was the result of...

Please describe your area of complaint and list them in order of severity. If you have only one area of complaint; ***skip*** the sections labeled **"Second Complaint"** and **"Third Complaint".**

First Complaint: Area of Pain: _____

The pain is... ❑ Constant
❑ Intermittent; it usually lasts for_____ ❑ minute(s) ❑ hour(s)❑ day(s) ❑ week(s)

1) What level is your pain **RIGHT NOW?** Please choose the number that best describes your pain in the question below **:**

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
None **1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** Unbearable Pain

The pain is aggravated by**:** _____

The pain is relieved by**:** _____

Name: _____ Date: _____

Bay State Chiropractic
Eric Diener, D.C.

Second Complaint: Area of Pain: _____

The pain is... ❑ Constant
❑ Intermittent; it usually lasts for _____❑ minute(s) ❑ hour(s) ❑ day(s) ❑ week(s)

1) What level is your pain **RIGHT NOW**? Please choose the number that best describes your pain in the question below:

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑
None **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

Third Complaint: Area of Pain: _____

The pain is... ❑ Constant
❑ Intermittent; it usually lasts for _____❑ minute(s) ❑ hour(s) ❑ day(s) ❑ week(s)

1) What level is your pain **RIGHT NOW**? Please choose the number that best describes your pain in the question below:

❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑ ❑
None **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** Unbearable Pain

The pain is aggravated by: _____

The pain is relieved by: _____

In general my symptoms are better in: ❑ AM ❑ Midday ❑ PM.

❑ Symptoms do not change with the time of day

Do you have night pain unrelated to movement? ❑ Yes ❑ No

Are your symptoms : ❑ improving ❑ unchanged ❑ getting worse.

Medical History

Do you NOW have any of the following conditions:

❑ Congestive heart failure
❑ Chronic lung disease (including bronchitis or emphysema)
❑ Blindness or trouble seeing, even when wearing glasses
❑ Deafness or trouble hearing
❑ Sugar diabetes (diabetes mellitus)
❑ Allergies
❑ Asthma
❑ Ulcer or gastrointestinal bleeding (not counting hemorrhoids)
❑ Hemorrhoids
❑ Arthritis or rheumatism
❑ Other

❑ Sciatica or chronic back problem
❑ Hypertension or high blood pressure
❑ Angina
❑ Heart attack or myocardial infarction
❑ Stroke
❑ Kidney disease
❑ Cancer
❑ Depression
❑ Pregnant
❑ Pacemaker

Name: _____Date:_____

Please list any history of illness, injuries, hospitalizations or surgeries……..

Date or Age: ________ ❑ Illness/Injury ❑ Hospitalization ❑ Surgery: ____________________________________
❑ Still have problem ❑ Still suffer occasionally from problem ❑ Complete recovery
Date or Age: ________ ❑ Illness/Injury ❑ Hospitalization ❑ Surgery: ____________________________________
❑ Still have problem ❑ Still suffer occasionally from problem ❑ Complete recovery
Date or Age: ________ ❑ Illness/Injury ❑ Hospitalization ❑ Surgery: ____________________________________
❑ Still have problem ❑ Still suffer occasionally from problem ❑ Complete recovery
Date or Age: ________ ❑ Illness/Injury ❑ Hospitalization ❑ Surgery: ____________________________________
❑ Still have problem ❑ Still suffer occasionally from problem ❑ Complete recovery
Date or Age: ________ ❑ Illness/Injury ❑ Hospitalization ❑ Surgery: ____________________________________

List medications you are currently taking, prescribed or over the counter:

1. ____ for ______________________________________
2. ____ for ______________________________________
3. ____ for ______________________________________
4. ____ for ______________________________________
5. ____ for ______________________________________

Do you have a primary care / family physician? ❑ Yes ❑ No;

If Yes, Name: ____ Location / Town: ________________________

Have you seen specialist(s) for this condition? ❑ Yes ❑ No

If. Yes, Name: ____ Location / Town: ________________________

If Yes, Name: ____ Location / Town: ________________________

Social History

Educational Level: ❑ Less than 12 years ❑ High school ❑ 1-4 years of college
❑ Beyond *4* years of college ❑ Professional school

Do you smoke? ❑ No ❑ Yes - If yes, how many packs of cigarettes do you smoke per day?
❑ less than *1/2* pack ❑ 1/2 to 1 pack ❑ 1 to 2 packs ❑ more than 2 packs

How many cups of coffee or caffeinated drinks do you have per day? ______
Do you consume alcohol? ❑ No ❑ Yes If yes, how many drinks in an average day?
❑ less than 1 ❑ no more than 1 ❑1 or 2 drinks ❑ 6 to 8 drinks ❑ more than 8 drinks

Do you have a regular program of exercise? ❑ No ❑ Yes
If yes, please note the frequency and type of exercise and list any hobbies or recreational sports you enjoy:

Name: ____ Date: _______________