Weymouth Specific Chiropractic * Dr. David M. Burgdorf * 317 Libbey Pkwy, # B-600 * Weymouth, MA 02188 * 781-337-4400

DATE: ___/___/___

# PATIENT HISTORY
**Welcome To Our Office !**

Office I.D. #

**Name:** _____
**Address:** _____
**City:** _____ **ST:**_____ **Zip:** _____
**Home Phone:** (_____) - _____ - _____
**Work Phone:** (_____) - _____ - _____
**Cell Phone:** (_____) - _____ - _____
**Cell Carrier:** AT&T Verizon Sprint _____?
**Date of Birth:** _____/_____/_____ **Age:** _____
**Height:** _____**ft.** _____**in.** **Weight:** _____**lbs.**
**Marital Status: S M W D Spouse:** _____

**Employer:** _____
**Occupation:** _____

**Emergency Contact Person:**
_____
**Relation:** _____
**Phone:** (_____) - _____ - _____

**Your Email Address:** ( for our monthly newsletters only. It **will not** be shared ).

## HEALTH PROBLEMS / COMPLAINTS

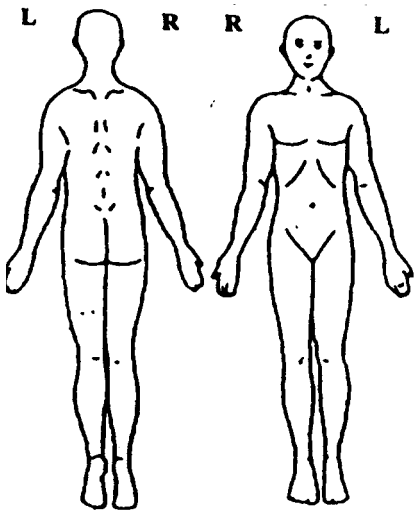
[ ] I am here for a general health evaluation [ ] I am suffering from a particular health problem(s).
**What caused this problem?** [ ] Auto-Accident [ ] Work-Injury [ ] Fall-Slip [ ] Overexert [ ] Gradual [ ] Unknown

**Please describe your complaints:**
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

What treatments or tests have you had and what results did you see? ___
_____

**Have you missed work because of this**? [ ] Yes [ ] No
How much and when?

**Clearly mark the pain location(s)**




**When did this first begin?** _____ **Are these problems getting worse?** [ ] Yes [ ] No
**How often does it occur?** [ ] Occasional [ ] Frequent [ ] Constant [ ] Varies [ ] Other _____
**Describe the problem:** [ ] Mild [ ] Moderate [ ] Severe [ ] Pains vary depending on activity or position._____
**Character of problem?** [ ] Sharp [ ] Ache [ ] Burn [ ] Numb [ ] Varies [ ] Other _____
**What relieves it?** [ ] Rest [ ] Drugs [ ] Ice [ ] Exercise [ ] Nothing [ ] Other _____
**What aggravates it?** [ ] Sitting [ ] Standing [ ] Lifting [ ] Bending [ ] Lying [ ] Driving [ ] Other_____
**Do the problems interfere with..?** [ ] Sleep [ ] Daily living [ ] Work ...**How?** _____

Who is your primary physician? _____ Phone # (_____)-_____-_____
When was your last physician visit? Date: _____/_____/_____ Reason: _____
Have you seen other Chiropractors? [ ] Yes [ ] No Name: _____
What results did you see?

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## Drugs / Supplements / Chemicals

List ANY **over-the-counter** or **prescription** medications.

| Medications | For What? | How often? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List ANY **vitamins or supplements** that you are taking.

_____

_____

**Which of the following do you use and how much?**

[ ] Tobacco _____
[ ] Coffee _____
[ ] Tea _____
[ ] Alcohol _____
[ ] Sodas _____
[ ] Sweeteners _____
[ ] Fast food _____
[ ] Junk food _____

**PREGNANCY ( females only)**

It is often clinically necessary to take x-rays to provide proper care, but is contra-indicated if you are pregnant.

**ARE YOU PREGNANT? [ ] Yes [ ] No [ ] Maybe**

First day of last menstrual period _____/_____/_____

[ ] Hysterectomy [ ] Tubal Ligation [ ] Menopause

## Past History

**Please list previous accidents/injuries, hospitalizations:**

_____

_____

**Major childhood traumas:**_____

_____

**List past surgeries and dates**: _____

_____

**Broken bones:**_____

**Allergies:** _____

**Any problem history with the following areas?**

| | | | |
|---|---|---|---|
| Cancer | N | Y | _____ |
| Diabetes | N | Y | _____ |
| Heart | N | Y | _____ |
| Respiratory | N | Y | _____ |
| Skin | N | Y | _____ |
| Genito-Urinary | N | Y | _____ |
| Gastro-Intestine | N | Y | _____ |
| Ear, Eye, Nose | N | Y | _____ |
| HIV positive | N | Y | _____ |

**Any other particular health conditions?** [ ] Yes [ ] No

Explain: _____

**Family History**

Age of your parents and state of health? _____

_____

If deceased, cause of death? _____

Your siblings, ages, and health? _____

_____

Your children, ages, and health? _____

_____

**Additional Comments:** _____

_____

## Authorization and Assignment of Benefits

By my signature below, I certify that the above information is correct. I authorize Weymouth Specific Chiropractic, P.C. to perform an examination, take x-rays if necessary, and administer chiropractic treatment. I authorize Weymouth Specific Chiropractic, P.C. to contact other health care providers I have to coordinate my care, and to release information to any other providers for coordination of care.

I further authorize the release of my health information to any insurance company, adjustor, or attorney as deemed necessary to process any claim for reimbursement purposes for any charges incurred at this office. I authorize and assign direct payment to Weymouth Specific Chiropractic P.C. and/or Dr. David M. Burgdorf P.C. by any insurance company or attorney obligated to reimburse me for services rendered at this office. I understand that I am ultimately responsible for any outstanding amounts, deductibles, or co-payments.

**Patient Signature**: _____ **Date**:_____/_____/_____ **Soc.Sec.#**_____

Guardian Signature: _____ **Date**:_____/_____/_____ **Soc.Sec.#**_____

**DO NOT WRITE BELOW THIS LINE / OFFICE USE ONLY**

Patient Accepted for care? [ ] Yes [ ] No [ ] Referred Reviewed By: _____ Dr. David M. Burgdorf

Weymouth Specific Chiropractic * Dr. David M. Burgdorf * 317 Libbey Parkway * Suite B-600 * Weymouth, MA 02189

# REVIEW OF SYSTEMS

**Name:** _____ **Date:** _____/_____/_____

**Please Check Off All Conditions That You Have or Have Had Below**

| | GENERAL |
|---|---|
| | POOR SLEEP |
| | FATIGUE |
| | NO APPETITE |
| | WEIGHT LOSS |
| | WEIGHT GAIN |
| | INFECTIONS |
| | EXCESS THIRST |
| | FEVER / CHILLS |
| | ANEMIA |
| | NIGHT SWEATS |

| | DIGESTIVE |
|---|---|
| | HEARTBURN |
| | VOMITING |
| | NAUSEA |
| | BLOODY STOOL |
| | I.B.S. CRAMPS |
| | COLITIS |
| | CROHN'S |
| | DIARRHEA |
| | CONSTIPATION |
| | RECTAL BLOOD |

| | REPRODUCTIVE |
|---|---|
| | PELVIC PAIN |
| | PAINFUL PERIOD |
| | INFERTILITY |
| | IMPOTENCE |

| | NERVE SYSTEM |
|---|---|
| | STROKE |
| | HEADACHES |
| | POOR BALANCE |
| | DIZZINESS |
| | NUMB / TINGLE |
| | WEAKNESS |
| | BLACKOUTS |
| | SHAKING |

| | IMMUNE SYSTEM |
|---|---|
| | ALLERGIES |
| | CANCER |
| | AIDS / H.I.V. |

| | LYMPH * BLOOD |
|---|---|
| | GLAND SWELL |
| | EASY BLEEDER |
| | SLOW HEALER |

| | ENDOCRINE |
|---|---|
| | DIABETES |
| | THYROID |
| | HOT FLASHES |

| | PSYCHIATRIC |
|---|---|
| | ANXIETY |
| | DEPRESSION |
| | MENTAL ILLNESS |
| | HALLUCINATE |

| | HEAD - E.E.N.T. |
|---|---|
| | SINUS PAIN |
| | BLURRED VISION |
| | EYE PAIN |
| | HEARING LOSS |
| | RINGING EARS |
| | SWALLOW PAIN |
| | CONGEST NOSE |
| | SORE THROATS |

| | MUSCLE * JOINT |
|---|---|
| | SWOLLEN JOINT |
| | STIFF JOINT |
| | STIFF MUSCLES |
| | ACHEY MUSCLE |
| | STIFF NECK |
| | BACK PAIN |
| | PAIN WALKING |

| | SKIN / BREAST |
|---|---|
| | RASHES |
| | MOLE PROBLEM |
| | SKIN CANCER |
| | HAIR DANDRUFF |
| | ECZEMA |
| | PSORIASIS |
| | BREAST LUMPS |
| | BREAST PAINS |
| | NIPPLE FLUID |

| | HEART |
|---|---|
| | HI BLOOD PRES |
| | LO BLOOD PRES |
| | CHEST PAIN |
| | PALPITATIONS |
| | HEAVY CHEST |
| | ANKLES SWELL |

| | LUNGS |
|---|---|
| | COUGH |
| | SHORT BREATH |
| | ASTHMA |
| | SPIT BLOOD |
| | SLEEP APNEA |

| | URINARY |
|---|---|
| | EXCESS URINE |
| | URINE PAIN |
| | BLOOD URINE |
| | LEAKY BLADDER |

**Reviewed by Dr. Burgdorf with patient on:**

_____/_____/_____

**Comments:**

_____

_____

_____

_____

**Patient Signature:** _____ **Date:** _____/_____/_____

# NOTICE OF PRIVACY

**Weymouth Specific Chiropractic * 317 Libbey Parkway, Suite B-600 * Weymouth, MA 02189**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

## OUR LEGAL DUTY

*Law Requires Us to:*

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and rights regarding your medical information.
3. Follow the terms of the current notice.

*We Have the Right to:*

1. Change our privacy practices and terms of this notice at any time. Provided that the changes are permitted by law.
2. Make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

*Notice of Change to Privacy Practices:*

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on this notice.

**FOR TREATMENT**: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT**: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

## PRIVACY PRACTICE ACKNOWLEDGEMENT

I have read the Notice of Privacy and I have been provided an opportunity to review it.

**Patient Signature**: _____ **Date**:_____/_____/_____