Harvard Chiropractic
257 Ayer Road
Harvard, MA 01451

CONFIDENTIAL PATIENT HEALTH RECORD

Patient Name: _____ Today's Date: _____

Email: _____

Date of Birth: _____ Sex: Male / Female

Address: _____

City:_____ State: _____ Zip Code:_____

Home Phone: _____Cell Phone: _____

Status: (*Please Circle*) Single Married Divorced Widowed

How did you hear about us?_____

Spouses Name: _____

Children (Names & Ages):_____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone: _____

Relationship (*Please Circle*) Spouse Relative Friend Other:_____

EMPLOYMENT INFORMATION:

Business Name: _____

Business Address: _____

Business Phone #: _____

Occupation: _____

INSURANCE INFORMATION: (*Please present your insurance card to the front desk)*

Health Insurance Company:_____

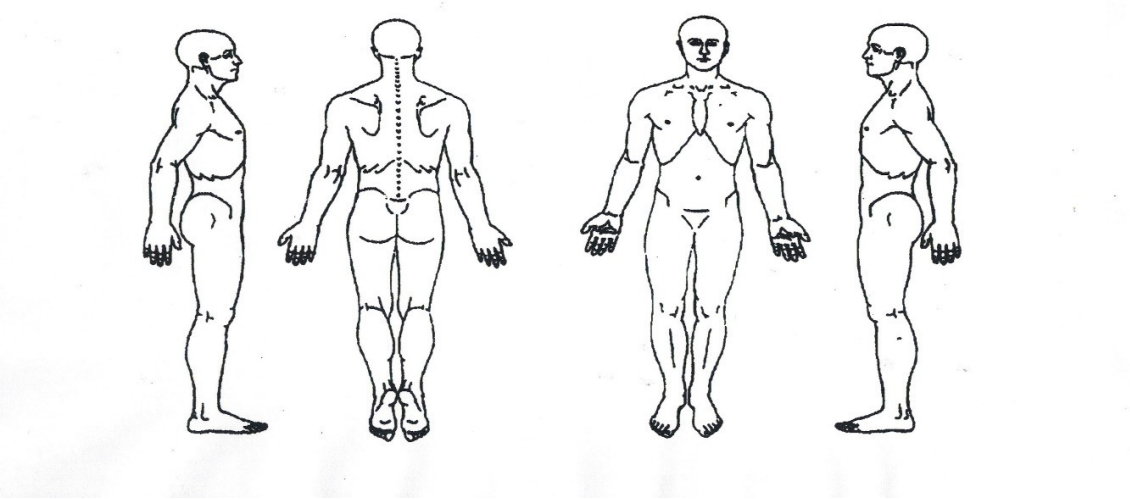
Subscriber ID #: _____

Policy Holder Name: _____

Policy Holder's Date of Birth: _____ Relationship to Insured: _____

1. Is today's problem caused by: Auto Accident **OR** Workman's Compensation *(please circle)*

2. Circle on the drawings below where you have pain/symptoms:



3. Please list the pain/symptoms that you are currently experiencing:

_____

_____

4. How often do you experience your symptoms? *(please circle)*

Constantly (76-100% of the time) **Occasionally** (26-50% of the time)

Frequently (51-75% of the time) **Intermittently** (1-25% of the time)

5. How would you describe the type of pain? *(please circle)*

Sharp	**Burning**	**Tingly**
Numb	**Shooting**	**Sharp with Motion**
Diffuse	**Stiff**	**Electric like with motion**
Achy	**Numb**	**Other:_____**

6. How are your symptoms changing with the time? *(please circle)*

Getting Worse **Staying the Same** **Getting Better**

7. Using a scale from 0 – 10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 *(please circle)*

8. How much has the problem interfered with your work? *(please circle)*

Not at all **A little bit** **Moderately** **Quite a bit** **Extremely**

9. How much has the problem interfered with your social activities? *(please circle)*

Not at all **A little bit** **Moderately** **Quite a bit** **Extremely**

10. Who else have you seen for your problem? *(please circle)*

Chiropractor	**Neurologist**	**Primary Care Physician**
ER Physician	**Orthopedist**	**No One**
Massage Therapist	**Physical Therapist**	**Other: _____**

11. How long have you had this problem?_____

12. How do you think your problem began? _____

13. Do you consider this problem to be severe? **Yes** **Yes, at times** **No**

14. What aggravates your problem? (Example: sleeping, sports, working, driving)

_____

15. What decreases or alleviates your symptoms? (Example: heat, ice, medication, resting)

_____

16. What concerns you the most about your problem; what does it prevent you from doing?

_____

17. What is your: Height: _____ Weight: _____ Age: _____

18. How would you rate your overall health? (*please circle*)

Excellent **Very Good** **Good** **Fair** **Poor**

19. What type of exercise do you do? (*please circle)*

Strenuous **Moderate** **Light** **None**

20. Indicate if you have any immediate family member with any of the following: (*please circle*)

Rheumatiod Arthritis **Diabetes** **Lupus**

Heart Problems **Cancer** **ALS**

21. On the line next to each of the conditions listed below; Write a **C** if you ***currently*** have a condition listed. Write a **P** if you have had a condition listed in the ***past.***
Leave space blank if you NEVER had any of the conditions.

_____ **Headache**
_____ **Neck Pain**
_____ **Upper Back Pain**
_____ **Mid Back Pain**
_____ **Lower Back Pain**
_____ **Shoulder Pain**
_____ **Elbow/Upper Arm Pain**
_____ **Wrist Pain**
_____ **Hand Pain**
_____ **Hip Pain**
_____ **Upper Leg Pain**
_____ **Knee Pain**
_____ **Ankle/Food Pain**
_____ **Jaw Pain**
_____ **Joint Pain/Stiffness**
_____ **Arthritis**
_____ **Rheumatoid Arthritis**
_____ **Cancer**
_____ **Tumor**
_____ **Asthma**
_____ **Chronic Sinusitis**
_____ **Other:** _____

_____ **High Blood Pressure**
_____ **Heart Attack**
_____ **Chest Pain**
_____ **Stroke**
_____ **Angina**
_____ **Kidney Stones**
_____ **Kidney Disorder**
_____ **Bladder Infection**
_____ **Painful Urination**
_____ **Loss of Bladder Control**
_____ **Prostrate Problems**
_____ **Abnormal Weight Gain/Loss**
_____ **Loss of Appetite**
_____ **Abdominal Pain**
_____ **Ulcer**
_____ **Hepatitis**
_____ **Liver/Gall Bladder Disorder**
_____ **General Fatigue**
_____ **Muscular Incoordination**
_____ **Visual Disturbances**
_____ **Dizziness**

_____ **Diabetes**
_____ **Excessive Thirst**
_____ **Frequent Urination**
_____ **Smoking/Tobacco Use**
_____ **Drug/Alcohol Dependence**
_____ **Allergies**
_____ **Depression**
_____ **Systemic Lupis**
_____ **Epilepsy**
_____ **Dermatitis/Eczema/Rash**
_____ **HIV/Aids**

FEMALES ONLY :

_____ **Birth Contril Pills**
_____ **Pregnancy**
_____ **Hormonal Replacement**

22. List all Prescription medications you are currently taking:

_____

23. List all the over-the-counter medications you are currently taking:

_____

24. List any nutritional supplements you are currently taking:

_____

25. List all surgical procedures you have had:

_____

26. What activities do you do at work: *(please circle)*

SIT - - - - - - - - - - - - - → Most of the day Half the day A little of the day

STAND - - - - - - - - - - - → Most of the day Half the day A little of the day

COMPUTER WORK- - - → Most of the day Half the day A little of the day

ON THE PHONE - - - - - → Most of the day Half the day A little of the day

27. What activities do you do outside of work *(Example: hobbies, recreation*)

_____

28. Have you ever been hospitalized? **No** **Yes**

If yes, why: _____

29. Have you even been treated by a chiropractor before? **No** **Yes** If Yes, When _____

30. Have you had significant past trauma? **No** **Yes**

31. Have you had the following routine screenings in the past 5 years? *(circle all that apply)*

Cholesterol **Prostrate (Men)** **Pap Smear (Women)** **Colonoscopy**

32. Anything else pertinent to your visit today?

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Harvard Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Harvard Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 for treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care and I give my authority for these procedures to be performed. It is understood and agreed the amount paid to this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office.

Patient Name: _____ Date: _____

Patient Signature: _____

Consent to treat a Minor:_____

Relationship to Minor:_____

(parent or guardian signature)

Harvard Chiropractic

BOURNEMOUTH QUESTIONNAIRE FOR PAIN

NAME_____ DATE OF BIRTH_____

Please check the area(s) for which you are seeking chiropractic care:

Neck_____ Back _____ Both_____ Other (specify)_____

The following scales have been designed to find out about your pain and how it is affecting you. Please answer **ALL** the scales by circling **ONE** number on each that best describes how you feel:

1. Over the past week, on average, how would you rate your pain? (No pain -0- **to** extreme -10-)

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your pain interfered with your daily activities (housework, washing, dressing, lifting, reading, and driving)? (None -0- **to** Not at all able -10-)

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your pain interfered with your ability to take part in recreational, social, and family activities? (None -0- **to** Not at all able -10-)

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling? (Little -0- **to** greater -10 -)

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, low spirits) have you been feeling?

(Not at all -0- **to** extremely depressed -10-)

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside & outside the home) has been affected (or would affect) your pain? (Little affect **-0-** **to** greater affect -10-)

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your pain on your own?

(Completely -0- **to** not whatsoever -10-)

0 1 2 3 4 5 6 7 8 9 10

Signature Date

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NON-COVERED SERVICES CONSENT

Name_____Acct #:_____

I understand that the services listed below may not be considered eligible for benefits.

- Examinations [99202] $95 - $125
- Re-Examinations [99211, 99213, 99201] $35-$85
- Spinal Manipulation [98941] $65
- Active Release Therapy 1 $10 (1 - 2 areas)
- Active Release Therapy 2 $20 (3 – 4 areas)
- Active Release $35 (5 + areas)
- Traction [97012] $35
- Electric muscle stimulation [97014] $35
- Home exercise instruction [97110] $35

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services.

Since I have chosen to obtain the services listed above, I agree to be financially responsible for any and all related charges, since they may not be covered by my insurance.

_____

Printed Name of Patient

_____ _____

Signature of Patient (or Guardian if patient is a minor) DATE

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Protecting your privacy is important to us. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances where we may have to use or disclose your health information:

1. We may have to disclose information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health.
2. We may have to disclose information and billing records to another party if they are potentially responsible for the payment of your services.
3. We may have to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent (164.520). We reserve the right to change our privacy practice as described in that notice. If any changes are made, you will be notified in writing by this office. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USE OF DISCLOSURES:

You have a right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place restriction of the use of your health information, please do so in writing. We are not required to agree to your restrictions. However, if we agree the restriction is binding.

YOUR RIGHT TO REVOKE AUTHORIZATION:

You may revoke your consent to us at any time; but is must be done in writing. We will not be able to honor your revocation request if we have already released your health information prior to receiving your request. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest your claims.

APPOINTMENT REMINDER AND HEALTH CARE INFORMATION AUTHORIZATION:

Your chiropractor and members of our staff at Harvard Chiropractic need to use your name, address, phone number, and your records to contact you with appointment reminders, or other health related information that might interest you. If this contact is made by phone and you are not home, a message will be left on your answering machine. By signing this form you are giving us authorization to do so.

You may restrict the individuals or organizations to which your health information is released, or you may revoke your authorization to us at any time. However, your revocation must be done in writing and mailed to your office address. We will not be able to honor any revocation request if we have already released your health information prior to our office receiving your request to revoke authorization. In addition, if you were required to give your authorization as a condition of obtaining health insurance, the company may have a right to your health information if they decide to reject a claim.

Information we use or disclose based on the authorization you're giving may be subject to re-disclosure by anyone who has access to reminder or other information and may no longer be protected by the federal privacy rules. You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment we provide to you or the method we use to obtain reimbursement for your care.

You may inspect a copy of the information we use to contact you to provide appointment reminders, information or other health related information at any time. (164.524).

I have read your consent policy and agree to its terms. I am also acknowledging that I have received or been offered a copy of this notice.

This notice is effective as of the date listed below. Authorization will expire seven years after the date of which you last received services from us. I authorize you to use or disclose my health information in the manner described above.

Patient name printed: _____ Date:_____

Patient signature: _____

Employee witness: _____