South Shore Family Chiropractic: 33 Sea Street, Weymouth, MA 02191: (781) 335-7671

We offer a unique service to individuals and families
We are happy you have chosen to use our services
We will make every effort to make your experience supportive, informative and healing
Please complete the following:

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Date of Birth _____ Age _____ Marital Status S M Loved One

Employment Status: Full-Time Part-Time Student Retired Unemployed

Occupation _____ Employer _____

Business Address _____

Significant Other's Name _____ Significant Other's Occupation _____

Name & Ages of Children _____

How did you hear about us? _____

Name & Relation of Person Who Referred You _____

Are you planning on using some type of insurance or third party reimbursement? __ Y __ N

Person Responsible for Account _____

Signature _____ Today's Date _____

Continued on Next Page

The goal of chiropractic care is to keep the body free from vertebral subluxations.
Today, we will explain to you exactly what vertebral subluxations are and evaluate your spine.

Reason for Consulting our office _____

Previous chiropractic care __ Y __ N With Whom _____

How Long _____ Date of Last Visit _____

Why did you stop care _____

Circle any of the following symptoms that you have experienced in the past 6 months:

Headaches	Neck Pain	Muscle Spasms	Nervousness
Migraine/Tension Headaches	Tension Across Shoulders	Irritability	Menstrual Problems
Shoulder Pain	Leg/Foot Pain	Dizziness	Fatigued, Tired
Arm/Hand Pain	Tingling in Legs/Feet	Allergies	Difficulty Sleeping
Tingling in Arms/Hands	Knee Pain	Depression	Difficulty Bending
High Blood Pressure	Mid-Back Pain	Digestive Problems	Physical Weakness
Jaw Pain (TMJ)	Low Back Pain	Weight Trouble	Asthma
	Fibromyalgia	Ringing in ears	Several Flus / Colds

Other Health Problems:_____

How committed are you to your HEALTH?
1. Not at all 2. Somewhat 3. My health is very important to me!

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WORKER'S COMPENSATION QUESTIONAIRE

Type of work being done at time of injury:_____
_____
In your own words, please describe accident:_____
_____
_____
_____

Injuries Involving Lifting-

From where were you lifting the object? _____
How many pounds was the object you were lifting? _____
What position were you in while lifting the object?_____
What type of pain did you feel immediately after the injury? _____

Injuries Involving Falling-

Where at work did you fall? _____
What part of your body did you land on?_____
What other areas were you injured as a result of your fall? _____

Job Analysis-

What regular activities do you perform at your job?_____
_____
How much do you regularly lift at your job?_____
Are you required to regularly bend over while lifting at your job?_____
Are your hands subject to repetitive movements?_____Such as?_____
_____

How many hours are your required to regularly perform each of the following activities at your job?

Sitting:_____
Standing:_____
Walking:_____
Lifting:_____

Other Work Related Injuries(If not caused by lifting or falling):_____
_____
_____

Date of Injury:_____
Have you returned to work since your accident?_____Yes ____No
If Yes, date you returned to work:_____

Have you been treated by another doctor for this accident?____Yes ____No
If yes, please list doctor's name and address:_____
What type of treatment did you receive?_____

Chiropractic

South Shore Family

Dr. William M. Byrnes
Director

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Today, we will explain to you exactly what vertebral subluxations are and evaluate your spine.

Continued on reverse side →

33 Sea Street
No. Weymouth, MA 02191

e-mail: ssfamilychiro@comcast.net
web: www.ssfamily.com

(781) 335-7671
Fax (781) 335-7856

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Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands to perform an adjustment in order order to realign your vertebrate. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may also feel movement of the joint.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. . A minority of patients may notice muscle stiffness or soreness after the first few days of adjustments similar to after a new workout. Rare complications while extremely unlikely can include fracture, ligamentous sprain, or injury to intervertebral discs. These complications are only seen with an inherent weakness in the body already present and our exam process is designed to pick up these red flags.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as very rare, about as often as complications are seen from taking a single aspirin tablet.

Other Treatment Options: No other profession is trained to find and correct your subluxations.

Risks of Remaining Untreated: Delay of treatment allows degenerative changes to continue and these changes can further reduce skeletal mobility and increase nerve irritation. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

No Warranty: I understand that my doctor at South Shore Family Chiropractic, cannot make any promises or guarantees regarding improvement in my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic care and will discuss treatment option with me. I have read the explanation above of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of chiropractic care. I have freely decided to undergo the recommended care plan, and herby give my full consent to receive chiropractic care.

_____ _____ _____

Printed Name Signature Date

Consent to Treat Minor – For use when applicable I hereby authorize South Shore Family Chiropractic doctors of chiropractic, to administer chiropractic care, as deemed necessary, to my child.

_____ _____ _____

Printed Name Signature Date

Please Help Us By Updating Your Info!

Name:_____

Address: _____

_____

Phone Number:_____

Email:_____

Chiropractic
South Shore Family

Dr. William M. Byrnes
Director

Privacy Policy Acknowledgement

Name:

Patient Acknowledgement:

I acknowledge that I have read/received a copy of South Shore Family Chiropractic's Notice of Privacy Practices in accordance with federal regulations dictated by the Health Insurance Portability and Accountability Act.(HIPAA).

Signature of Patient	Print Name	Date
Signature of Parent/Guardian	Print Name	Date

33 Sea Street
No Weymouth, MA 02191

e-mail: ssfamilychiro@comcast.net
web: www.ssfamily.com

(781) 335-7671
Fax (781) 335-7856

NEW PATIENT REGISTRATION

South Shore Family Chiropractic

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Email _____

City _____ State _____ Zip _____

(_____) _____ _____
Home Telephone Cell Number Work Telephone

Date of Birth _____ Age _____ Social Security # _____

Insurance Company _____ Insurance ID # _____ Co-Pay/Deductible _____ # Visits PCY _____

Marital Status: Single Married Other **Sex:** Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME & ADDRESS - Person to Bill if Other Than Patient _____

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to South Shore Family Chiropractic and understand I am financially responsible for any and all non-covered services provided by South Shore Family Chiropractic.*

Signature: _____ **Date:** _____