

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

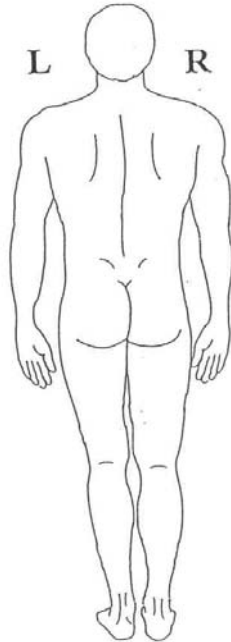
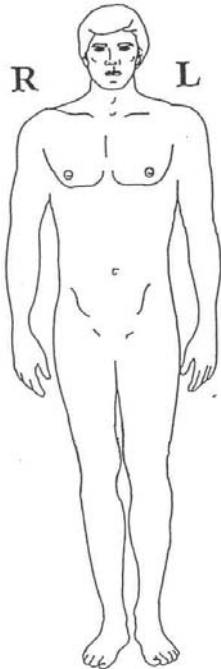
I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT BAY STATE CHIROPRACTIC WILL PREPARE THE NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY, AND THAT ANY 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 _____

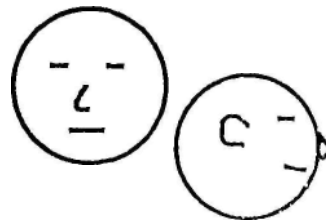
Current Complaint

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:

- | | |
|----------------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Sciatica or chronic back problem |
| <input type="checkbox"/> Chronic lung disease (including bronchitis or emphysema) | <input type="checkbox"/> Hypertension or high blood pressure |
| <input type="checkbox"/> Blindness or trouble seeing, even when wearing glasses | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Deafness or trouble hearing | <input type="checkbox"/> Heart attack or myocardial infarction |
| <input type="checkbox"/> Sugar diabetes (diabetes mellitus) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ulcer or gastrointestinal bleeding (not counting hemorrhoids) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Arthritis or rheumatism | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Other | |

Name: _____ Date: _____

Bay State Chiropractic - Weymouth
Eric Diener, D.C.

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: _____
 Still have problem Still suffer occasionally from problem Complete recovery

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: _____

Bay State Chiropractic
Eric Diener, D.C.