WE'D LIKE TO GET TO KNOW YOU BETTER!

Name:_____Birthdate:_____

Address:_____City/St._____Zip_____

Home Phone:_____Cell:_____Work:_____

Email:_____

Single:_____ Married_____ Divorced_____ Widowed _____ Separated_____

Occupation:_____Employer:_____

Primary Care Doctor:_____

Who shall we call in case of emergency?_____

Their phone number:_____

Who referred you to our office?_____

Have you undergone chiropractic care before?_____

When_____Where_____

PRIVACY NOTICE ACKNOWLEDGEMENT:

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I waive my right to privacy regarding the daily sign-in sheet for purposes of proof of attendance.

I acknowledge that I have been offered a copy of NEEDHAM CHIROPRACTIC ASSOCIATES' "Notice of Privacy Practices for Protected Health Information".

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature Authorized Provider Rep. Signature

HEALTH HISTORY

Please Print Name:_____
Date:_____

1. My health goals are:
   - ____correction/stabilization
   - ____health maintenance
   - ____pain relief

2. Please check area(s) of complaint:

____low back pain	_____neck pain
____hip/buttock pain. __R__L	_____shoulder pain. __R __L
____leg pain. __R __L	____arm ____hand pain. __R __L
____foot pain __R __L	____mid-back pain.
____other_____ (Specify)	____headache.

3. When did the pain begin? Approximate date:_____
   - ____gradually, without incident.
   - ____with specific incident.

4. Explain the accident/injury or how you think it occurred: _____

_____

5. What makes the symptoms worse?

____sitting	____looking down
____getting out of a chair	____sneezing
____getting out of bed	____coughing
____turning in bed	____having a bowel movement
____backing up the car	____other- please specify: _____

6. How does the pain feel?

____sharp	____burning	____other – please specify:
____dull	____numbness	_____
____throbbing	____tingling	_____
____cramping	____weak or lame	

7. Does the pain or symptom travel from one site to another?
   ____No ____Yes Explain:_____

_____

8. How much does it hurt? **0 1 2 3 4 5 6 7 8 9 10** (0=no pain 10=severe and incapacitating pain)

9. Does your pain change with activity? ____No____Yes
Explain:_____
_____

PLEASE CHECK THE FOLLOWING:

1. Have you ever had cancer? ____Yes ____No
2. Does your pain ever awaken you from a sound sleep? ____Yes ____No
3. Are you losing weight now, without trying? ____Yes ____No
4. Are you coughing up blood or noticing it in your stools or urine? ____Yes ____No
5. Have you had any loss of bladder or bowel control? ____Yes ____No
6. Have you lost consciousness or had double vision recently? ___Yes ____No
7. Do you have a pace maker? ____Yes ____No
8. Are you seeing any other doctor now for any reason? ____Yes ____No
   Specify:_____
9. Do you have any other symptoms or health problems? ____Yes ____No
   Specify:_____
10. Are you taking any medications or over the counter drugs now, (i.e. anti-coagulants)?
    ____Yes ____No List them:_____
11. Do you have any food or drug allergies (i.e. shellfish)? ____Yes ____No
    List them:_____

PAST TREATMENT HISTORY:

_____
_____
_____
_____
_____
_____

FINANCIAL AND APPOINTMENT POLICIES

PAYMENT IS DUE AS SERVICES ARE RENDERED

We gladly accept Cash, Checks, and all Major Credit Cards.

INSURANCE: Health care policies of insurance companies with whom this office participates will try to be verified. Verification is not a guarantee of coverage or payment. Any insurance questions should be directed to your insurance carrier. We will accept assignment as specified for insurance plans we participate with. **Patients are responsible for all deductible amounts, co-payments and non-covered services. It is the patient's responsibility to keep track of how many visits are allowed and used on their insurance.** For all other insurance companies patients are required to pay at the time of service.

MISSED APPOINTMENTS: Please try to notify our office as soon as possible of an appointment change so that we can accommodate your needs as well as the needs of other patients. Patients may be charged a missed appointment fee of $45.00 without 24 hour notice prior to a scheduled visit. This charge is a patient's responsibility and cannot be billed to insurance.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility, due and payable at the time services are rendered. If you have a flex spending or employer contribution account, we will provide you with receipt for reimbursement. Payment is due at the time of service.

_____ _____

Patient Signature **Date**

ASSIGNMENT OF BENEFITS:

I hereby authorize and direct Needham Chiropractic Associates, P.C. to release medical information necessary to process my insurance claims. I also authorize and direct my insurance carrier to pay all benefits, which may be due to me according to my policy, to Needham Chiropractic Associates, P.C.

_____ _____

Patient Signature **Date**

PATIENT INFORMED CONSENT

PATIENT NAME:_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:
___spinal manipulative therapy___palpation___vital signs___range of motion testing
___orthopedic testing___basic neurological testing___muscle strength testing ___postural analysis testing

The risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risk occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include: self administered, over-the-counter analgesics and rest. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers. Hospitalization. Surgery.

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (Minor)

I hereby request and authorize Needham Chiropractic Associates, Drs. Nathaniel Tiplady and Justin Culici to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____.
This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable)
Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Nathaniel Tiplady and/or Dr. Justin Culici and have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:_____**

_____ **_____**

Patient's Name **Doctor's Name**

_____ **_____**

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)