Welcome to
Community Chiropractic of Acton

Today's Date _____

Personal Data

Name _____ Date of Birth _____ Gender M F T

Home Phone (_____)_____ Email Address _____

Cell Phone (_____)_____ Cell Carrier (needed for text reminders) _____

[**Please indicate your preferred phone number with an ***]

Home Address _____ City _____ State ____ ZIP _____

Marital Status: S M D W L/W D/P Name of Spouse _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ ZIP _____

Business Phone (_____)_____

Whom may we thank for referring you to our office? _____

Reasons for Seeking Chiropractic Care

What concerns do you feel our office can address for you?

_____

_____

Is this concern affecting any of the activities below?

Work: Y N	Recreation/Play: Y N	Sleep: Y N
Social Life: Y N	Walking: Y N	Sitting: Y N
Exercise: Y N	Eating: Y N	Love life: Y N

Other Data

Have you ever received Chiropractic Care? Y N With whom? _____

Date of last visit: _____ Why did you stop care? _____

Do you have a family doctor? Y N Who? _____

Do you consult him/her regularly? Y N If so, why? _____

Date of last medical consultation and result: _____

Date of last menstruation, if applicable: _____

Health, Wellness, and Chiropractic Care

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

History of Physical Stresses (Birth to Present)

Birth Stress

Research indicates that the birth process can cause trauma to a baby's spine and nerve system.
Please indicate to the best of your recollection how you were birthed:

Was your birth: (circle all that apply)

Drug induced	C section	Breech	Natural	Forceps	Suction
Prolonged	Cord around neck		At home	In hospital	

General Physical Trauma

Most trauma occurs in the early years (between birth and age 18-21). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (circle all that apply and give dates)
Automobile (even as a passenger) Motorcycle Bicycle Sports Other _____
If yes, please explain how and when:

_____

_____

Have you ever injured your spine (neck, head, back, hips)? Y N
If yes, please explain how and when:

_____

_____

Have you ever broken any bones or sprained any part of your body? Y N
If yes, please explain how and when:

_____

_____

Have you ever been hospitalized? Y N
If yes, please explain how and when:

_____

_____

History of Chemical Stresses

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated? Y N

Do you or have you ever taken? prescription drugs over the counter drugs recreational drugs

Have you been exposed to? chemicals fumes dust smoke

Do you consume? alcohol coffee/caffeine tobacco

List Current Medications:

_____

Any Medications Previously taken for more than 6 months?_____

History of Emotional Stresses

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

Childhood trauma	Loss of loved one	Relationships	Family
Work or School	Divorce/separation	Financial	Abuse
Lifestyle change	Parents' divorce	Illness	Other

<u>Quality of Life</u>

How do you grade your physical health?	Good	Fair	Poor
How do you grade your emotional/mental health?	Good	Fair	Poor
How do you rate your overall "quality of life"?	Good	Fair	Poor

Financial Information

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

The cash fee for a new patient is $200.00, which includes the first consult, a chiropractic exam, a computerized posture analysis, x-rays if necessary, a report of findings, and the first adjustment

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process, please fill out the “Insurance Permission” section below.

Signature _____ Today’s Date _____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:

“I authorize Community Chiropractic of Acton to release to my insurance company any medical or other information necessary to process my insurance claims. I authorize payment to be made directly to Community Chiropractic of Acton. I permit a copy of this authorization to be used in place of the original.”

Signature: _____ Date _____

Also, if you are not the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber’s name: _____ Subscriber’s date of birth: _____

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Community Chiropractic of Acton to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not to be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- We would like to be able to refer others to speak with you about your experience at Community Chiropractic of Acton.
- We often take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Community Chiropractic of Acton. This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

We at Community Chiropractic of Acton 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, if asked, to supply you with a copy of our privacy policies and procedures. If you would like to read this document, please ask our front desk staff. 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 practice member/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 acknowledge that I am able to receive and review a copy of Community Chiropractic of Acton Notice of Privacy Practices for Protected Health Information. Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____	_____	_____
Patient name printed	Patient Signature	Date

Terms and Consent to Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

The objective of chiropractic health care in this office is to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations. Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, _____ (print name) have read and fully understand the above.

I therefore accept chiropractic care on this basis.

_____ _____

Patient Signature Date

Credit Card Authorization

Name: _____ Date: _____

Last First Middle Initial

I,_____, give authorization for Community Chiropractic of Acton to charge my credit card for any and all services rendered to me. I acknowledge that I am legally responsible for any and all charges and I authorize my credit card to be charged the total of any back balance if I decide to discontinue my care.

( ) MasterCard ( ) Visa ( ) Discover ( ) AMEX ( ) FSA/HSA

Credit Card Number:_____

Expiration Date:_____ Security Code(3 digits):_____

Address of Credit Card:_____ Zip Code: _____

Signature: _____ Date: _____

Our purpose is to educate and adjust families toward optimal health with natural chiropractic care.