PATIENT HISTORY FORM

Name _____ Date _____

Address _____ City _____ State _____ Zip _____
Cell Phone ____/____/_____ Work ____/____/_____ ext:____ Home ____/____/_____
E-Mail address (emergencies + newsletters, never shared)_____
Date of Birth ____/____/_____ Age _____ Height ___ft.____in. Weight _____
Marital Status M S W D Name of Spouse _____
Children? Y N Names/Ages of Children _____
Employer _____ Occupation _____
Emergency Contact Person _____ Relation _____
Address _____ City _____ State _____ Zip _____
Phone ____/____/_____ Who referred you here? _____

COMPLAINTS/HEALTH PROBLEMS

☐ I am here for a general health evaluation. ☐ I am suffering from a particular health problem.
Please describe your complaints, including when and how they started:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

What treatments and tests have you received for your problems so far?

_____

What are your problems preventing you from doing? Sports _____ Hobbies _____
Family/Kids _____ Work _____ Other _____
Have you seen other chiropractors? Y N Name:_____
Location _____ Reason/diagnosis _____
List past surgeries and dates _____

_____

Who is your primary physician? Name _____ Location _____
When was your last physician visit? Date:_____ Reason:_____
Do you smoke now? Y N Have you ever smoked? Y N
If yes, how long, how much, and when did you quit? _____
Please list previous accidents/injuries, including major childhood traumas with dates and hospitalizations:

_____
_____

Explain your job requirements-positions/postures _____
List vitamins and supplements you take _____

_____

List over the counter medication _____
List prescription medication _____
(Females only) Are you taking birth control pills? Y N Have you in the past? Y N _____
What childhood illnesses have you had (measles, chicken pox, etc.)? __Usual Other: _____

Check any of the following conditions you have had or do have:

Patient name printed _____ DOB _____

__ Allergies __ Drug Allergies	__ Eczema	__ Neck Pain
__ Sinus Problems	__ Other Skin Problems	__ Mid Back Pain
__ Asthma	__ Headaches	__ Low Back Pain
__ Anemia	__ Migraines	__ Shoulder Pain L R
__ Arthritis	__ Heart Disease	__ Elbow Pain L R
__ Cancer	__ Heart Attack	__ Hand Pain L R
__ Depression	__ Menstrual Problems	__ Hip Pain L R
__ Diabetes	__ Multiple Sclerosis	__ Leg Pain L R
__ Digestive Problems	__ Stroke	__ Knee Pain L R
__ Drug Abuse/Addiction	__ Weight Problems	__ Foot Pain L R
__ Alcoholism	__ Ringing in Ears	__ Carpal Tunnel L R
__ Stress	__ Dizzy/Balance Problems	__ Other _____

Are your parents alive? **Y N** If alive, what is their state of health? _____
If deceased, cause of death: _____
Siblings, ages, and health: _____
☐ Yes ☐No Any personality/emotional changes? If so, what? _____
☐ Yes ☐No Any changes to your sense of smell?
☐ Yes ☐No Do you see spots or any disturbances to your vision?
☐ Yes ☐No Does your heart feel like it races?
☐ Yes ☐No Any changes in bowel/bladder function? If so, what? _____
☐ Yes ☐No Any changes in sexual function? If so, what? _____
☐ Yes ☐No Have you noticed any short or long-term memory changes?
☐ Yes ☐No Any changes in your energy level such as fatigue?
☐ Yes ☐No Do you have any muscle twitches?
☐ Yes ☐No Do you exercise regularly? If so, what kind of exercise? _____
Are you a healthy eater? **Y N** An unhealthy eater? **Y N** Somewhere in-between? **Y N**
Can you eat anything you want? **Y N** If not, what do you avoid? _____
Do you drink regular soda? **Y N** Diet soda/drinks? **Y N** If yes, how many/day? _____
Do you consume caffeine (coffee, soda, tea)? **Y N** If so, how much? _____

CONSENT TO TREATMENT AUTHORIZATION

By my signature below, I certify that the above information is correct. I authorize Fuller Chiropractic, P.C. to perform an examination, take x-rays if necessary, and administer chiropractic treatment. I authorize Fuller Chiropractic to contact other health care providers I have to coordinate my care, and to release information to my other providers for coordination of care, and to release my health information for insurance reimbursement purposes.

Patient Signature **(X)** _____ Date _____

INSURANCE ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct _____ Insurance Company to make payment directly to: FULLER CHIROPRACTIC, 827 Main Street, Woburn, MA 01801, the professional or chiropractic benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as the original dated at Woburn, Massachusetts this _____ day of _____ 20____.

Patient Signature **(X)** _____

By my signature below, I understand that if my health insurance denies the charges, I am responsible for payment of my bill.

Patient Signature **(X)** _____

Patient name printed _____ DOB _____

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 acknowledge that I have been offered a copy of Fuller Chiropractic, P.C.'s Notice **of Privacy Practices for Protected Health Information**, and I have been told that a copy is available at the front desk at any time.

Patient Signature **(X)** _____ Date _____

PATIENT PREGNANCY DISCLAIMER (FEMALES ONLY)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken at this time and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time,

_____ I am sure that I am not pregnant
_____ It is possible that I could be pregnant
_____ I am pregnant

Patient Signature **(X)** _____ Date _____

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.

Authorized Provider Representative _____ Date _____

Witnessing signing of: ☐ Authorization to treat ☐ Insurance assignment ☐ Privacy Notice ☐ Pregnancy Disclaimer

Doctor's notes _____

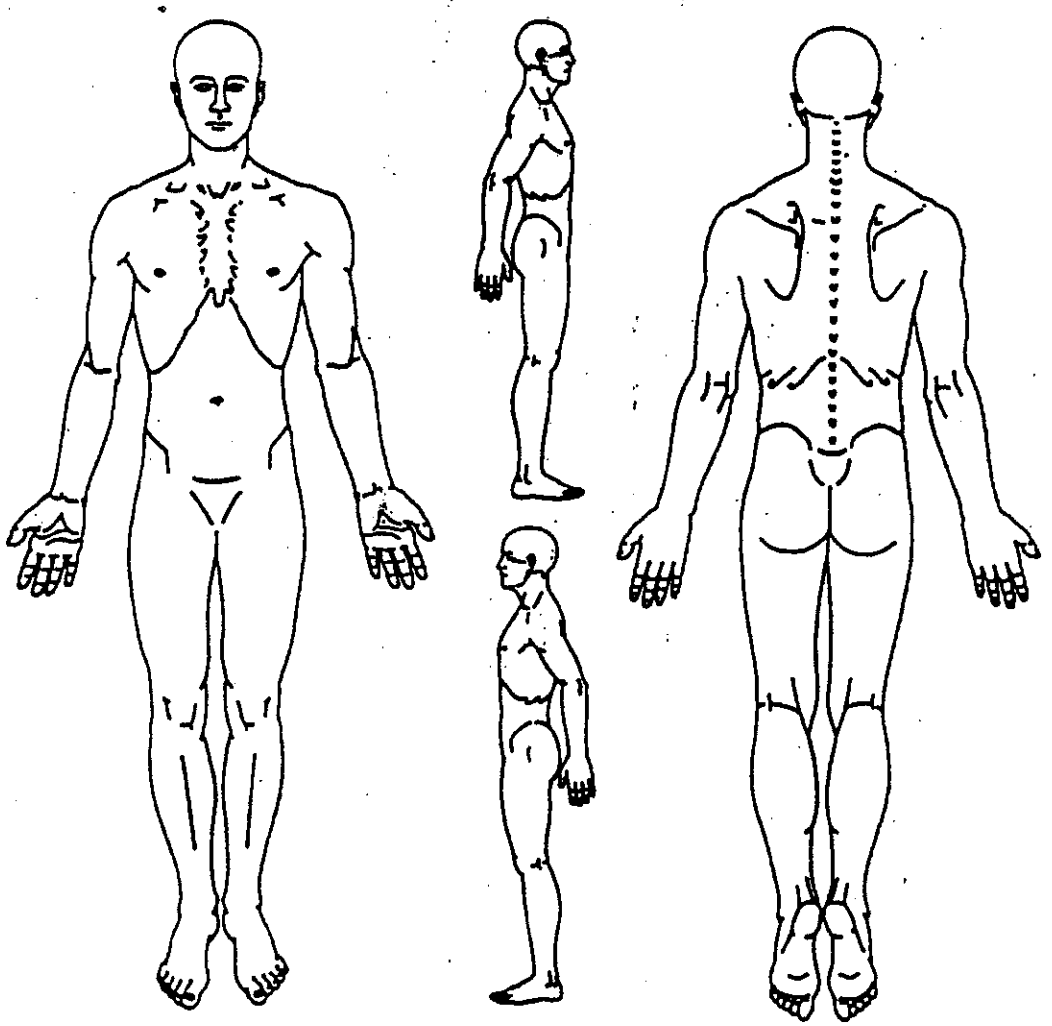
P A I N D I A G R A M

DOB _____

Patient Name: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING *"PAIN DIAGRAM"* BY USING LETTERS BELOW TO INDICATE ON THE DIAGRAM YOUR AREAS OF PAIN:

A = ACHE	**B = BURN**	**D = DULL PAIN**	**N = NUMBNESS**
P = SHARP PAIN	**S = STIFFNESS**	**T = PINS/NEEDLES/ TINGLING**	**O = OTHER**



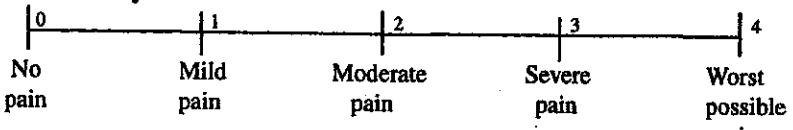
Patient's Signature: _____

Functional Rating Index

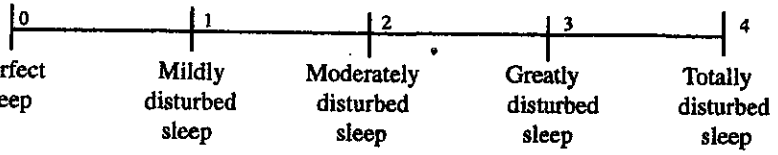
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

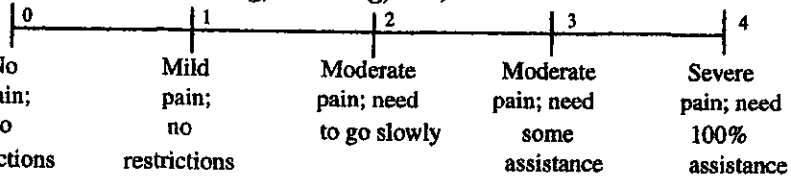
1. Pain Intensity



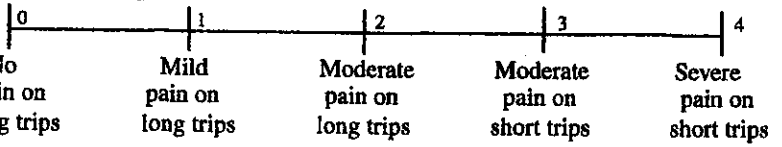
2. Sleeping



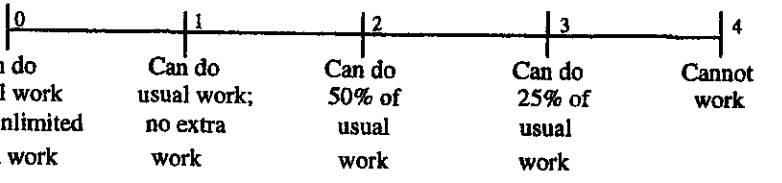
3. Personal Care (washing, dressing, etc.)



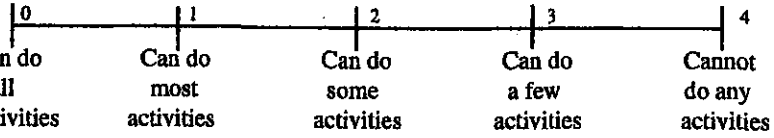
4. Travel (driving, etc.)



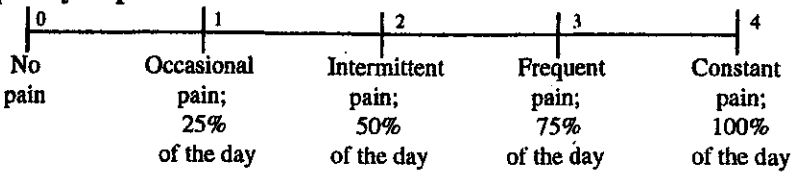
5. Work



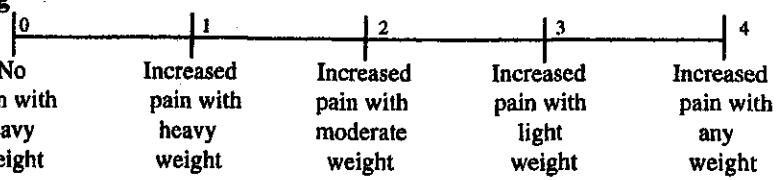
6. Recreation



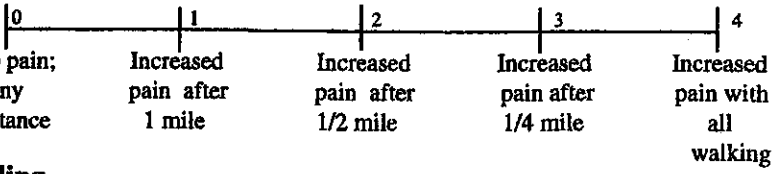
7. Frequency of pain



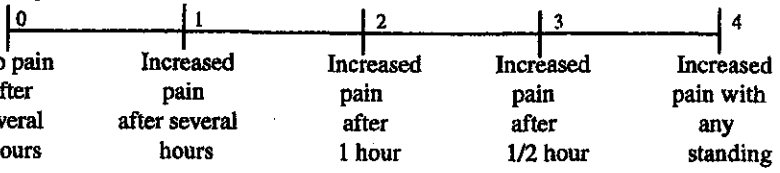
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

Fuller Chiropractic 827 Main St. Woburn, MA 01801 781-933-3332

Review of Systems

Patient Name: _____ Signature: _____ Today's Date: ____/____/____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
☐**None**
☐Chills
☐Daytime Drowsiness
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Gain
☐Weight Loss

Eyes/Vision:
☐**None**
☐Blindness
☐Blurred Vision
☐Cataracts
☐Change in Vision
☐Double Vision
☐Eye Pain
☐Field Cuts
☐Glaucoma
☐Itching *(around the eyes)*
☐Photophobia
☐Tearing
☐Wears Glasses or Contacts

Ears, Nose and Throat:
☐**None**
☐Bleeding
☐Dental Implants
☐Dentures
☐Difficulty Swallowing
☐Discharge
☐Dizziness
☐Ear Drainage
☐Ear Infection*(s)*
☐Ear Pain
☐Fainting
☐Headaches
☐Head Injury *(history of)*
☐Hearing Loss
☐Hoarseness
☐Loss of Smell
☐Nasal Congestion
☐Nose Bleeds
☐Post Nasal Drip
☐Rhinorrhea *(runny nose)*
☐Sinus Infections
☐Snoring
☐Sore Throats
☐Tinnitus *(ringing in the ears)*
☐TMJ Disorder

Respiration:
☐**None**
☐Asthma
☐Coughing up blood
☐Shortness of Breath
☐Sputum Production
☐Wheezing

Cardiovascular:
☐**None**
☐Angina *(chest pain or discomfort)*
☐Chest Pain
☐Claudication *(leg pain or achiness)*
☐Heart Murmur
☐Heart Problems
☐Orthopnea *(difficulty breathing while lying)*
☐Palpitations *(irregular or forceful heart beat)*
☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
☐Shortness of Breath
☐Swelling of Leg*(s)*
☐Ulcers
☐Varicose Veins

Gastrointestinal:
☐**None**
☐Abdominal Pain
☐Belching
☐Black, Tarry Stools
☐Constipation
☐Diarrhea
☐Difficulty Swallowing
☐Heartburn
☐Hemorrhoids
☐Indigestion
☐Jaundice *(yellowing of the skin)*
☐Nausea
☐Rectal Bleeding
☐Abnormal Stool Caliber *(quality)*
☐Abnormal Stool Color
☐Abnormal Stool Consistency
☐Vomiting
☐Vomiting Blood

Female:
☐**None**
☐Birth Control Therapy
☐Breast Lumps / Pain
☐Burning Urination
☐Cramps
☐Frequent Urination
☐Hormone Therapy
☐Irregular Menstruation
☐Urine Retention
☐Vaginal Bleeding
☐Vaginal Discharge

Male:
☐**None**
☐Burning Urination
☐Erectile Dysfunction
☐Frequent Urination
☐Hesitancy or Dribbling
☐Prostate Problems
☐Urine Retention

Endocrine:
☐**None**
☐Cold Intolerance
☐Diabetes
☐Excessive Appetite
☐Excessive Hunger
☐Excessive Thirst
☐Frequent Urination
☐Goiter
☐Hair Loss
☐Heat Intolerance
☐Unusual Hair Growth
☐Voice Changes

Skin:
☐**None**
☐Changes in Nail Texture
☐Changes in Skin Color
☐Hair Growth
☐Hair Loss
☐Hives
☐Itching
☐Paresthesia (numbness, prickling, or tingling)
☐Rash
☐History of Skin Disorders
☐Skin Lesions or Ulcers
☐Varicosities

Nervous System:
☐**None**
☐Dizziness
☐Facial Weakness
☐Headaches
☐Limb Weakness
☐Loss of Consciousness
☐Loss of Memory
☐Numbness
☐Seizures
☐Sleep Disturbance
☐Slurred Speech
☐Stress
☐Strokes
☐Tremors
☐Unsteadiness of Gait

Psychological:
☐**None**
☐Anhedonia *(inability to experience joy or enjoy life)*
☐Anxiety
☐Appetite Changes
☐Behavioral Change*(s)*
☐Bipolar Disorder
☐Confusion
☐Convulsions
☐Depression
☐Insomnia
☐Memory Loss
☐Mood Change*(s)*

Allergy:
☐**None**
☐Anaphylaxis *(history of)*
☐Food Intolerance
☐Itching
☐Nasal Congestion
☐Sneezing

Hematology:
☐**None**
☐Anemia
☐Bleeding
☐Blood Clotting
☐Blood Transfusion*(s)*
☐Bruises easily
☐Fatigue
☐Lymph Node Swelling