Wilmington Back & Spine

299 Main St.
Wilmington, MA 01887
Phone: (978) 988-9588

Personal Information

First _____ **M** _____ **Last** _____ **Nickname** _____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Social Security # _____ **Gender M/F** **Marital Status** _____ **Spouse** _____

Date of Birth _____ **Email Address:** _____

Height: _____ **Weight** _____ **Employed? Y N** **Employer Name:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Children? Y N **If yes, number of children?** _____ Ages of children: _____

Names of children: _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

How did you hear about Wilmington Family Chiropractic? _____

Health Insurance Information

Do you have health insurance coverage? ❑ Yes ❑ No

Name of Insured (if not self) _____ **Birthdate of Insured** _____ **SS#** _____

Insurance Carrier _____ **Policy Number** _____ **Co-Payment** _____

Insured's Employer _____ **Address** _____

Are you covered by any other insurance? ❑ Yes ❑ No

Insurance Carrier _____ **Policy Number** _____ **Co-Payment** _____

Reason for the Appointment

Describe your condition(s)/symptoms/pain _____ **Date Condition Started** _____

_____

_____

On a Scale of 1 - 10 with 10 being the worst, circle the pain you currently have:

1 2 3 4 5 6 7 8 9 10	**1 2 3 4 5 6 7 8 9 10**	**1 2 3 4 5 6 7 8 9 10**	**1 2 3 4 5 6 7 8 9 10**	**1 2 3 4 5 6 7 8 9 10**
Neck Pain	**Mid Back Pain**	**Low Back Pain**	**Headaches**	**Shoulder Pain**

1 2 3 4 5 6 7 8 9 10 (describe other pain and location) _____

Other Pain _____

Treatment and Diagnostic History

Diagnostic Testing (X-ray, MRI, EMG, etc.)	Body Area	Date	Facility	Finding

Diagnostic tests that have been performed for the current chief complaint include:

Prior Physician: _____ **Date of 1st Visit:** ___/___/___

Date of Last Visit: ___/___/___

Physician's Diagnosis: _____

Treatment Recommended by Prior Physician (mark all that apply)

- ❑ Adjustments ❑ Immobilization ❑ Analgesics ❑ Nerve Blocks
- ❑ Bed Rest ❑ Massage ❑ Anti-Biotics ❑ Sedatives
- ❑ Heat ❑ Physical Therapy ❑ Anti-Inflammatories ❑ Trigger Point Injections
- ❑ Ice ❑ Rehabilitation ❑ Muscle Relaxants ❑ Surgery

Treatment Results (mark one)

- ❑ Plan was not followed ❑ Had some success
- ❑ Aggravated the conditic ❑ Relieved the condition
- ❑ Offered no relief or benefit

Social History

Marital Status?
- ❑ Married
- ❑ Divorced
- ❑ Single
- ❑ Separated
- ❑ Widowed

# of Children?
- ❑ No children ❑ 4 children ❑ 8 children
- ❑ 1 child ❑ 5 children ❑ 9 children
- ❑ 2 children ❑ 6 children ❑ 10 children
- ❑ 3 children ❑ 7 children

How often do you exercise?
- ❑ never
- ❑ rarely
- ❑ occasionally
- ❑ regularly

Hand of Dominance?
- ❑ Left
- ❑ Right
- ❑ Ambidextrous

Hours of Sleep per night?
- ❑ 1 hour
- ❑ 2 hours
- ❑ 3 hours
- ❑ 4 hours
- ❑ 5 hours
- ❑ 6 hours
- ❑ 7 hours
- ❑ 8 hours
- ❑ 9 hours
- ❑ 10 or more

Participation in Sports Activities?
- ❑ very frequently ❑ infrequently
- ❑ often ❑ almost never
- ❑ somewhat often ❑ never
- ❑ occasionally

Involvement in Hobbies?
- ❑ very frequently ❑ infrequently
- ❑ often ❑ almost never
- ❑ somewhat often ❑ never
- ❑ occasionally

Have you traveled internationally?
- ❑ never
- ❑ recently
- ❑ occasionally
- ❑ in the past

How often do you eat a well-balanced diet?
- ❑ never ❑ occasionally ❑ always
- ❑ rarely ❑ usually

Do you consider yourself overweight?
- ❑ yes
- ❑ no

How many pounds overweight?
- ❑ 5 ❑ 15 ❑ 25 ❑ 35 ❑ 45
- ❑ 10 ❑ 20 ❑ 30 ❑ 40 ❑ _____

Highest level of education achieved?
- ❑ Did not graduate ❑ Bachelor's Degree
- ❑ earned a GED ❑ Masters Degree
- ❑ graduated HighSchool ❑ PhD or Doctorate
- ❑ Associates Degree

Years of Education after High School?
- ❑ _____

Learning Disabilities?
- ❑ yes
- ❑ No
- ❑ unknown

Alcohol Consumption?
- ❑ does not drink alcoholic beverages
- ❑ drinks alcoholic beverages rarely
- ❑ drinks alcoholic beverages occasionally
- ❑ drinks alcholic beverages frequently
- ❑ drinks alcoholic beverages often
- ❑ usaully only drinks alcoholic beverages on the weekends

Recreational Drug Use? (optional)
- ❑ never
- ❑ occasionally
- ❑ often
- ❑ in the past

How often do you drink beverages with caffein
- ❑ never
- ❑ less than 1 caffeinated beverage per day
- ❑ 1-2 caffeinated beverages per day
- ❑ 2-3 caffeinated beverages per day
- ❑ 3-4 caffeinated beverages per day
- ❑ 4-5 caffeinated beverages per day
- ❑ more than 5 caffeinated beverages per day

Tobacco Use?

Years of Tobacco Use?
- ❑ _____

Cigarettes
- ❑ does not smoke ❑ 1 pack per day
- ❑ < 1/4 pack per day ❑ 2 packs per day
- ❑ 1/4 pack per day ❑ 3 packs or > per day
- ❑ 1/2 pack per day ❑ in the past

Chewing tobbaco
- ❑ never used
- ❑ occasionally
- ❑ often
- ❑ in the past

Cigars
- ❑ never used
- ❑ occasionally
- ❑ often
- ❑ in the past

Health History

Please select all choices that apply to you, either currently or in the past.

- ❑ Abdominal Pain
- ❑ Allergies
- ❑ Angina
- ❑ Anorexia
- ❑ Aortic Aneurysm
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disorder
- ❑ Breast Soreness
- ❑ Bulemia
- ❑ Cancer
- ❑ Colitis
- ❑ Convulsions
- ❑ Diabetes
- ❑ Dislocated Joints
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Hay Fever
- ❑ Headaches
- ❑ Heart Attacks
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Irregular Bowel Habits
- ❑ Irregular Menstrual
- ❑ Irritable Colon
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Painful Urination
- ❑ PMS
- ❑ Polio
- ❑ Profuse Menstrual
- ❑ Prostate Disease
- ❑ Rapid Heart Rate
- ❑ Rheumatic Fever
- ❑ Scoliosis
- ❑ Sexually Transmitted Diseases
- ❑ Sickle Cell Anemia
- ❑ Sinus Trouble
- ❑ Spinal Disc Disorder
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Vaginal Discharge
- ❑ _____

Are you presently taking any medications? If so, please list. _____

Have you had any surgeries? If so, please list. _____

Family History

	Mother	*Father*	*Siblings*	*Cousins*	*Maternal Grandmother*	*Maternal Grandfather*	*Paternal Grandmother*	*Paternal Grandfather*
Angina	❑	❑	❑	❑	❑	❑	❑	❑
Arthritis or Rheumatism	❑	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑	❑
Blindness*	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Chronic Bronchitis	❑	❑	❑	❑	❑	❑	❑	❑
Congestive Heart Failure	❑	❑	❑	❑	❑	❑	❑	❑
Deafness*	❑	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes Mellitus Type II	❑	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑
Sciatica/Chronic Low Back Pain	❑	❑	❑	❑	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑	❑	❑
Ulcers or GI Bleeding	❑	❑	❑	❑	❑	❑	❑	❑
OTHER:	❑	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑	❑

❑ Relatives Still Living
❑ Relatives In Good Health

***Blindness was caused by:**
- ❑ Cataracts
- ❑ Conginital absence of ability
- ❑ Glaucoma
- ❑ Trauma

***Deafness was caused by:**
- ❑ Conginital absence of ability
- ❑ Meniere's Disease
- ❑ Otic Cancer
- ❑ Trauma

Family history negative for:
- ❑ Cancer
- ❑ Diabetes
- ❑ Thyroid Disorders
- ❑ Heart Disease
- ❑ Stroke
- ❑ High Blood Pressure
- ❑ Asthma
- ❑ Seizures
- ❑ Liver Dysfunction
- ❑ Kidney Pathologies
- ❑ **All Of The Above**

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 received a copy of ***Wilmington Family Chiropractic's Notice of Privacy Practices for Protected Health Information.***

_____
Patient or Guardian Name Printed

_____ _____
Patient or Guardian Signature Date

CONSENT TO TREAT

I understand that all records established by this office are the sole property of Dr. Jensen. Copies, however, will be made upon 72 hours written notice to the doctor, and I understand and agree to pay all costs involved in their reproduction.

I hereby give Wilmington Family Chiropractic and Dr. Jensen CONSENT TO TREAT me and/or my minor child, and I understa Wilmington Family Chiropractic requires personal payment for all services rendered today.

I, the undersigned, hereby authorize Dr. Jensen (and whom he may designate his assistants) to administer any examination and/or treatment as is necessary and to perform appropriate diagnostic and therapeutic procedures as are considered necessary on the basis of findings during the course of said examination and/or treatment. I also authorize the release of any information or records from this office to other past, present or future health care professionals, facilities, attorneys or agencies for the purpose of continuity of my health care and for the purpose of collection for services rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Wilmington Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Wilmington Family Chiropractic and Dr. Jensen will be credited to my account on receipt. I also give Wilmington Family Chiropractic and Dr. Jensen limited power of attorney to endorse checks received from my insurance company relating only for my treatment, to be credited to my account. However, I clearly understand and agree that all services rendered to me and/or my minor child are charged directly to me and that I am personally responsible for payment, regardless of my insurance coverage. I also understand that if I suspend or terminate my care and treatment and/or if in the event that my insurance benefits are terminated or exhausted, any fees for professional services rendered to me and/or my minor child will be immediately due and payable.

I also certify that no guarantee has been made as to the results that may be obtained from any treatment given.

By signing below, I affirm that I have read the above and that it has been clearly explained to my as well by Wilmington Family Chiropractic.

_____ _____

Patient (or Guardian) Signature Date

FEMALE PATIENT X-RAY PREGNANCY VERIFICATION

I, _____, a patient of Wilmington Family Chiropractic, certify that to the best of my knowledge that I am not pregnant. By my signature below, I authorize Wilmington Family Chiropractic and Dr. Jensen to take all appropriate diagnostic x-rays. If there is even a remote chance of pregnancy, I will notify Dr. Jensen immediately.

Signed: _____ Date: _____

Doctor's Signature:_____ Date _____

ASSIGNMENT, LIEN AND AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION

Patient Name: _____

For good and valuable consideration received, I, _____, being the undersigned, authorize and direct you, _____ my insurance carrier to pay directly to WILMINGTON FAMILY CHIROPRACTIC any sums as may be due and owing this office for services rendered me, both by reason of accident, or illness and/or by reason of any other bills, medical payments, no-fault benefits, health and/or accident benefits, workers' compensation benefits, or any other insurance benefits or reimbursement for which you may be obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect WILMINGTON FAMILY CHIROPRACTIC and Dr. Stephen Jensen who provided these services.

I hereby give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract is to act as an assignment of my rights and benefits to the extent of the office's charges for services

In further consideration of the treatment rendered herein, I do hereby authorize WILMINGTON FAMILY CHIROPRACTIC to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I understand that by signing this document, I am authorizing release of reports and information to the above-indicated party, which could include the responsible party's insurance company.

Furthermore, I authorize WILMINGTON FAMILY CHIROPRACTIC to release any information pertinent to my case to any insurance company adjuster to facilitate collection under this assignment, lien and medical authorization.

In the event that the insurance company is obligated to make payments to me for charges made by this office for services rendered and refuses to make such payments, I hereby assign and transfer to this office any and all cause of action, claims, whether in law or equity, that I might have or that I might exist in my favor against such company, and authorize this office to compromise, settle or otherwise resolve any claim or cause of action in its sole discretion herein as it relates to amounts owed the doctor.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered to me and this agreement is made solely for said office's additional protection while awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

This agreement is irrevocable and is binding upon the heirs and executors of the undersigned.

_____ _____

Patient Signature Date