# BOSTON SPINE AND DISK CENTER

## 102 Charles Street, Boston MA 02114 Tel: 617-720-1992 Fax 617-248-9916

## PATIENT REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Email_____

Patient Last Name_____ First Name_____ Initial_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured Name_____ How and where did you learn about this clinic?_____

Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

| | |
|---|---|
| **EMPLOYER** | Company Name_____ Occupation_____<br>Address_____ Phone_____ ☐ Full-time ☐ Part-time<br>City_____ State_____ Zip_____ Years Employed_____ |
| **SPOUSE (PARENT)** | Name_____ Birthdate_____ SSN:_____<br>Last Name First Name Initial<br>Employer Name_____ Years Employed_____<br>Address_____ Phone_____ Occupation_____<br>City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time |
| **PATIENT INSURANCE INFORMATION** | Please list any and all insurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name_____<br>Policy/Group #:_____ Effective Date:_____<br>Name of Insured:_____ ID #:_____ |
| **SPOUSE COINSURANCE INFORMATION** | Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have<br>Insurance Company or Health Care Plan Name_____<br>Policy/Group #:_____ Effective Date:_____<br>Name of Insured:_____ ID #:_____ |
| **MEDICAL AND LEGAL INFORMATION** | **Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____<br>If you answered yes, please fill out accident specific form, available at the front desk.<br>Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____<br>Person to contact in emergency (Name and Phone #)_____<br>Attorney_____ Telephone:_____<br>Address |
| **Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws** | **Legal Assignment Of Benefits And Designation Of Authorized Representative**<br>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.<br>I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.<br><br>_____ _____<br>Signature of Insured / Guardian Date |

**1. The symptom(s) that have prompted me to seek care today include:** _____

_____

**2. And are the result of (darken circle):** ○ An accident or injury

○ Work ○ Auto ○ Other _____

○ A worsening long-term problem

○ An interest in: ○ Wellness ○ Other _____

**3. Onset** (When did you first notice your current symptoms?)

_____

**4. Intensity** (How extreme are your current symptoms?)

0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10

Absent Uncomfortable Agonizing

**5. Duration and Timing** (When did it start and how often do you feel it?)

○ Constant ○ Comes and goes. How Often? _____

_____

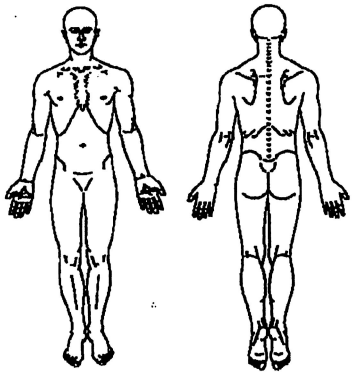
**6. Quality of symptoms** (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

**7. Location** (Where does it hurt?) Circle the area(s) on the illustration.

"0" for current condition

"X" for conditions experienced in the past



**8. Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

**9. Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

**10. Prior interventions** (What have you done to relieve the symptoms?)

○ Prescription medication ○ Surgery ○ Ice

○ Over-the-counter drugs ○ Acupuncture ○ Heat

○ Homeopathic remedies ○ Chiropractic Other _____

○ Physical therapy ○ Massage _____

**11. What else should Charles Street Family Chiropractic & Physical Therapy know about your current condition?** _____

_____

**12. How does your current condition interfere with your:**

**Work or career:** _____

**Recreational activities:** _____

**Household responsibilities:** _____

**Personal relationships:** _____

**13. Review of Systems**

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

**a. Musculoskeletal**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Osteoporosis | ○ | ○ | Arthritis | ○ | ○ | Scoliosis | ○ | ○ | Neck pain | ○ | ○ | Back problems | ○ | ○ | Hip disorders |
| ○ | ○ | Knee injuries | ○ | ○ | Foot/ankle pain | ○ | ○ | Shoulder problems | ○ | ○ | Elbow/wrist pain | ○ | ○ | TMJ issues | ○ | ○ | Poor posture |

NONE ○ Initials ____

**b. Neurological**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Anxiety | ○ | ○ | Depression | ○ | ○ | Headache | ○ | ○ | Dizziness | ○ | ○ | Pins and needles | ○ | ○ | Numbness |

NONE ○ Initials ____

**c. Cardiovascular**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | High blood pressure | ○ | ○ | Low blood pressure | ○ | ○ | High cholesterol | ○ | ○ | Poor circulation | ○ | ○ | Angina | ○ | ○ | Excessive bruising |

NONE ○ Initials ____

**d. Respiratory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Asthma | ○ | ○ | Apnea | ○ | ○ | Emphysema | ○ | ○ | Hay fever | ○ | ○ | Shortness of breath | ○ | ○ | Pneumonia |

NONE ○ Initials ____

**e. Digestive**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Anorexia/bulimia | ○ | ○ | Ulcer | ○ | ○ | Food sensitivities | ○ | ○ | Heartburn | ○ | ○ | Constipation | ○ | ○ | Diarrhea |

NONE ○ Initials ____

**f. Sensory**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Blurred vision | ○ | ○ | Ringing in ears | ○ | ○ | Hearing loss | ○ | ○ | Chronic ear infection | ○ | ○ | Loss of smell | ○ | ○ | Loss of taste |

NONE ○ Initials ____

**g. Skin**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Skin cancer | ○ | ○ | Psoriasis | ○ | ○ | Eczema | ○ | ○ | Acne | ○ | ○ | Hair loss | ○ | ○ | Rash |

NONE ○ Initials ____

Consultation Notes

Patient name

Doctor's Initials

*(Continued from previous page)*

**h. Endocrine**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Thyroid issues | ○ | ○ | Immune disorders | ○ | ○ | Hypoglycemia | ○ | ○ | Frequent infection | ○ | ○ | Swollen glands | ○ ○ | Low energy | Initials ____ |

**i. Genitourinary**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Kidney stones | ○ | ○ | Infertility | ○ | ○ | Bedwetting | ○ | ○ | Prostate issues | ○ | ○ | Erectile dysfunction | ○ ○ | PMS symptoms | Initials ____ |

**j. Constitutional**

| Had | Have | | Had | Have | | Had | Have | | Had | Have | | Had | Have | | NONE ○ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Fainting | ○ | ○ | Low libido | ○ | ○ | Poor appetite | ○ | ○ | Fatigue | ○ | ○ | Sudden weight gain/loss (circle one) | ○ ○ | Weakness | Initials ____ |

**Patient name** _____

○ All other systems negative

## Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

### 14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

| Had | Have | | Had | Have | |
|---|---|---|---|---|---|
| ○ | ○ | AIDS | ○ | ○ | Tuberculosis |
| ○ | ○ | Alcoholism | ○ | ○ | Typhoid fever |
| ○ | ○ | Allergies | ○ | ○ | Ulcer |
| ○ | ○ | Arteriosclerosis | ○ | ○ | Other: _____ |
| ○ | ○ | Cancer | | | _____ |
| ○ | ○ | Chicken pox | | | _____ |
| ○ | ○ | Diabetes | | | _____ |
| ○ | ○ | Epilepsy | | | _____ |
| ○ | ○ | Glaucoma | | | _____ |
| ○ | ○ | Goiter | | | _____ |
| ○ | ○ | Gout | | | _____ |
| ○ | ○ | Heart disease | | | _____ |
| ○ | ○ | Hepatitis | | | |
| ○ | ○ | HIV Positive | | | |
| ○ | ○ | Malaria | | | |
| ○ | ○ | Measles | | | |
| ○ | ○ | Multiple Sclerosis | | | |
| ○ | ○ | Mumps | | | |
| ○ | ○ | Polio | | | |
| ○ | ○ | Rheumatic fever | | | |
| ○ | ○ | Scarlet fever | | | |
| ○ | ○ | Sexually transmitted disease | | | |
| ○ | ○ | Stroke | | | |

### 15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

### 16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

| Past | Currently | |
|---|---|---|
| ○ | ○ | Acupuncture |
| ○ | ○ | Antibiotics |
| ○ | ○ | Birth control pills |
| ○ | ○ | Blood transfusions |
| ○ | ○ | Chemotherapy |
| ○ | ○ | Chiropractic care |
| ○ | ○ | Dialysis |
| ○ | ○ | Herbs |
| ○ | ○ | Homeopathy |
| ○ | ○ | Hormone replacement |
| ○ | ○ | Inhaler |
| ○ | ○ | Massage therapy |
| ○ | ○ | Physical therapy |
| ○ | ○ | Nutritional supplements: |

List: _____

○ ○ Medications (prescription and over-the-counter):

### 17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

### 18. Family History

Some health issues are hereditary. Tell Charles Street Family Chiropractic & Physical Therapy about the health of your immediate family members.

FAMILY

| Relative | Age (If living) | State of health | | Illnesses | Age at death | Cause of death | |
|---|---|---|---|---|---|---|---|
| | | Good | Poor | | | Natural | Illness |
| Mother | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Father | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Sister 1 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Sister 2 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Brother 1 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| Brother 2 | _____ | ○ | ○ | _____ | _____ | ○ | ○ |
| _____ | _____ | ○ | ○ | _____ | _____ | ○ | ○ |

**19. Are there any other hereditary health issues that you know about?** _____

_____

### 20. Social History

Tell Charles Street Family Chiropractic & Physical Therapy about your health habits and stress levels.

SOCIAL

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol use | ○ Daily | ○ Weekly | How much? _____ | Prayer or meditation? | ○ Yes | ○ No |
| Coffee use | ○ Daily | ○ Weekly | How much? _____ | Job pressure/stress? | ○ Yes | ○ No |
| Tobacco use | ○ Daily | ○ Weekly | How much? _____ | Financial peace? | ○ Yes | ○ No |
| Exercising | ○ Daily | ○ Weekly | How much? _____ | Vaccinated? | ○ Yes | ○ No |
| Pain relievers | ○ Daily | ○ Weekly | How much? _____ | Mercury fillings? | ○ Yes | ○ No |
| Soft drinks | ○ Daily | ○ Weekly | How much? _____ | Recreational drugs? | ○ Yes | ○ No |
| Water intake | ○ Daily | ○ Weekly | How much? _____ | | | |

Hobbies: _____

**Doctor's Initials** _____

**21. Activities of Daily Living**
How does this condition currently interfere with your life and ability to function?

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Sitting | ○ | ○ | ○ | ○ |
| Rising out of chair | ○ | ○ | ○ | ○ |
| Standing | ○ | ○ | ○ | ○ |
| Walking | ○ | ○ | ○ | ○ |
| Lying down | ○ | ○ | ○ | ○ |
| Bending over | ○ | ○ | ○ | ○ |
| Climbing stairs | ○ | ○ | ○ | ○ |
| Using a computer | ○ | ○ | ○ | ○ |
| Getting in/out of car | ○ | ○ | ○ | ○ |
| Driving a car | ○ | ○ | ○ | ○ |
| Looking over shoulder | ○ | ○ | ○ | ○ |
| Caring for family | ○ | ○ | ○ | ○ |

| | No Effect | Mild Effect | Moderate Effect | Severe Effect |
|---|---|---|---|---|
| Grocery shopping | ○ | ○ | ○ | ○ |
| Household chores | ○ | ○ | ○ | ○ |
| Lifting objects | ○ | ○ | ○ | ○ |
| Reaching overhead | ○ | ○ | ○ | ○ |
| Showering or bathing | ○ | ○ | ○ | ○ |
| Dressing myself | ○ | ○ | ○ | ○ |
| Love life | ○ | ○ | ○ | ○ |
| Getting to sleep | ○ | ○ | ○ | ○ |
| Staying asleep | ○ | ○ | ○ | ○ |
| Concentrating | ○ | ○ | ○ | ○ |
| Exercising | ○ | ○ | ○ | ○ |
| Yard work | ○ | ○ | ○ | ○ |

**22. What is the major stressor in your life?** _____

**23. How much sleep do you average per night?** _____ **Hours**

**24. What is the type and approximate age of your mattress and pillow?** _____

**25. What is your preferred sleeping position?** _____

**26. Describe your typical eating habits:** ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

**27. What would be the most significant thing that you could do to improve your health?** _____

**28. In addition to the main reason for your visit today, what additional health goals do you have?** _____

**Patient name** _____

***Consultation Notes***

**Acknowledgements**
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

**If the patient is a minor child, print child's full name:** _____

**Doctor's Initials** _____

Signature _____ Date (MM/DD/YYYY) _____