ESSEX FAMILY CHIROPRACTIC
51 Main St.
Gloucester, MA 01930
978-281-5131

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, insurance and billing issues, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of ___________________________. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_______________________________ _______________________________
Patient name printed Date

_______________________________ _______________________________
Patient Signature Authorized provider representative

_______________________________ _______________________________
Personal representative Printed Personal representative signature

____
Description of personal representative's authority to act for the patient

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CANCELLATIONS AND NO SHOWS

We strive to give the best service we can, utilizing a broad range of therapeutic techniques. This requires more time than usual for a chiropractic appointment; therefore we schedule only two to three patients per hour. If you find you cannot keep your appointment because of illness or conflicts in your schedule, please give us 24-hours notice prior to the time of your appointment. We will be glad to reschedule.

We would like you to take your appointments here very seriously because your commitment to treatment is essential to ensure the best gains and outcome possible. Missed appointments or cancelled appointments can prevent us from providing you with the best results possible and providing care to our other patients. So………

- PLEASE CALL AT LEAST 24 HOURS PRIOR TO THE SCHEDULED TIME OF YOUR APPOINTMENT FOR EMERGENCIES OR ILLNESS.
- 3 CONSECUTIVE CANCELLATIONS MAY MEAN TERMINATION FROM TREATMENT.
- 2 CONSECUTIVE NO SHOWS WILL REQUIRE TERMINATION
- FAILURE TO GIVE US 24 HOURS NOTICE OR FOR FAILING TO KEEP AN APPOINTMENT WILL RESULT IN A $25.00 CANCELLATION/NO SHOW FEE.
- YOU WILL BE DIRECTLY RESPONSIBLE FOR THIS FEE AS ALL INSURANCE COMPANIES (HEALTH, AUTO AND WORKMAN'S COMPENATION) WILL NOT PAY FOR MISSED APPOINTMENTS.

We thank you in advance for your cooperation. If you have any questions or concerns about our policy, please address them with the Office Manager.

I have read the policy on Cancellation and No shows, and understand that if I do not give notice 24 hours before my scheduled appointment, I will be responsible to pay a $25.00 Cancellation and/or No Show Fee.

______________________________ ____________________
Signature of Patient and/or Guardian Date

ESSEX FAMILY CHIROPRACTIC

51 Main St. Gloucester, MA 01930 978-281-5131

PATIENT INFORMATION DATE: ______________________

NAME: ____

ADDRESS: ____
(street) (city) (state) (zip code)

PHONE: Home: _____________________ Work: _______________________
Cell: ______________________

SEX: MALE FEMALE BIRTHDATE: _______________ AGE: ______
SOCIAL SECURITY NUMBER: ______________________________
SINGLE MARRIED WIDOWED SEPARATED DIVORCED
CHILDREN: YES NO HOW MANY: ________ AGES: _________________
OCCUPATION: ____

EMPLOYER: ____
ADDRESS OF EMPLOYER:____

SPOUSE'S NAME: ____

WHOM MAY WE THANK FOR REFERRING YOU? _________________________

IN CASE OF EMERGENCY, CONTACT: ___________________________________
PHONE NO.: __________________ RELATIONSHIP: __________________

INSURANCE INFORMATION

INSURANCE COMPANY: ____
ID #: _________________________ GROUP #: _________________________

DO YOU HAVE ADDITIONAL INSURANCE? YES NO
IF SO, NAME AND ID #: ____
SUBSCRIBER'S NAME: ________________________ BIRTHDATE: ___________
SUBSCRIBER'S RELATIONSHIP TO YOU: _______________________________

IS THIS CONDITION THE RESULT OF AN ACCIDENT? YES NO
IF YES, DATE OF ACCIDENT ______________________
TO WHOM HAVE YOU REPORTED THIS ACCIDENT?
AUTO INSURANCE EMPLOYER OTHER
HAVE YOU RETAINED AN ATTORNEY? YES NO
IF YES, ATTORNEY'S NAME: ______________________________________
PHONE NUMBER: ____

ESSEX FAMILY CHIROPRACTIC

HISTORY OF PRESENT COMPLAINT:

LIST THE PROBLEMS YOU WANT ADDRESSED:
(Please fill out one sheet for each problem you want examined. For example, headache, neck or back pain, shoulder pain numbness in fingers, foot pain, etc.)

1. Describe the problem ____
____

- When did it start? ____
- Have you had it before? __________ When? ____________________
- If it resulted from an injury, please describe ______________________________
____
- If not an injury, what do you think caused it? ______________________________
____
- Does it radiate or refer to other locations? ______________________________
____
- Rate the pain level from 1 to 10 ____
- Does the pain fluctuate or is it constant? ______________________________
- Circle the appropriate description of the problem: ache stiff sharp shooting burning throbbing numb tingling cramping other ______________________________
- Is it worse in the morning, later in the day, with movement? (please circle or underline)
- What makes it worse? ____
- Is it better after sleeping, after exercise, movement or stretching? Does ice or heat help? (please circle) Other ____
- Have you taken any medication for it? Yes/No If so, what ________________________ Was it helpful? Yes/No.
- Have you had any other treatment? Yes/No. IF so, what type ____________________, where ______________________________, by whom ______________________________. Was it helpful? Yes/No. Any comments: ______________________________
____
- Other information/notes about this problem ______________________________
____
____

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INFORMATION ABOUT MEDICAL HISTORY

WHAT DIAGNOSTIC IMAGING TESTING HAVE YOU HAD FOR THIS CONDITION?
X-RAY MRI CT SCAN OTHER

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP) ?
NAME: ______________________________
ADDRESS:______________________________
TELEPHONE:______________________________

WHEN WAS YOUR LAST PHYSICAL EXAM? ______________________________

WHEN WAS YOUR LAST DENTAL EXAM? ______________________________

HAVE YOU CONSULTED YOUR PCP ABOUT ANY ILLNESS IN THE PAST YEAR? YES NO
IF SO, PLEASE DESCRIBE ______________________________
____

LIST INJURIES/SURGERIES DESCRIPTION DATES/YEAR
FALLS ______________________________
HEAD INJURIES ______________________________
BROKEN BONES ______________________________
DISLOCATION ______________________________
SURGERIES ______________________________

HEALTH HABITS:

DO YOU EXERCISE? NOT AT ALL OCCASIONALLY REGULARLY
WHAT ACTIVITIES DOES IT INCLUDE ______________________________
WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR

DIETARY HABITS:

SMOKING PACKS/DAY ________ ALCOHOL DRINKS/WEEK ______________
COFFEE/TEA/CAFFEINATED SODA CUPS/DAY __________________
HOW MANY FRESH FRUITS DO YOU EAT PER DAY ____________________________
HOW MANY FRESH VEGETABLES DO YOU EAT PER DAY ______________________
HOW MANY COOKED VEGETABLES DO YOU EAT PER DAY ____________________
HOW WOULD YOU DESCRIBE YOUR DIET? ALL INCLUSIVE PARTIALLY VEGETARIAN
STRICT VEGETARIAN HEALTHY SOMEWHAT HEALTHY NEEDS WORK
HOW WOULD YOU DESCRIBE YOUR CURRENT STRESS LEVEL?
LOW STRESS MEDIUM STRESS HIGH STRESS
WHAT ARE THE CAUSES OF STRESS FOR YOU CURRENTLY? ______________________________
____
____

DO YOU FEEL DISCOMFORT IN YOUR MUSCLES, ETC. DURING STRESSFUL TIMES? YES NO
IF SO, DESCRIBE WHERE ______________________________
____

WHAT MEDICATIONS ARE YOU TAKING ______________________________
____

WHAT VITAMINS, HERBS, ETC. ARE YOU TAKING ______________________________
____

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REVIEW OF SYSTEMS

Circle any condition you have had

GENERAL
Allergy
Chills
Convulsions
Dizziness
Fainting
Fatigue
Fever
Headache
Loss of Sleep
Loss of weight
Nervousness/depression
Neuralgia
Numbness
Sweats Tremors

MUSCLE & JOINT
Arthritis
Bursitis
Foot trouble
Hernia
Low back pain
Lumbago
Neck pain or stiffness
Pain between shoulders
Pain or numbness in:
- Shoulders
- Arms
- Elbows

kidneys
- Hands
- Hips
- Legs
- Knees
- Feet

Painful tail bone
Poor posture
Sciatica
Spinal curvature
Swollen joints

GASTRO-INTESTINAL
Belching or gas
Colitis
Colon trouble
Constipation
Diarrhea
Difficult digestion
Distension of abdomen
Excessive hunger
Gall bladder trouble
Hemorrhoids
Intestinal worms
Jaundice
Liver trouble
Nausea
Pain over stomach
Poor appetite
Vomiting
Vomiting of blood

EYES, EARS, NOSE THROAT
Asthma
Colds
Crossed eyes
Deafness
Dental decay
Earache
Ear discharge
Ear noises

Enlarged glands
Enlarged thyroid
Eye pain
Failing vision
Far sightedness
Gum trouble
Hay fever
Hoarseness
Nasal obstruction
Near sightedness
Nose bleeds
Sinus infection
Sore Throat
Tonsillitis

CARDIO-VASCULAR
Hardening of arteries
High blood pressure
Low blood pressure
Pain over heart
Poor circulation
Rapid heart beat
Slow heart beat
Swelling of Ankles

RESPIRATORY
Chest pain
Chronic cough
Difficult breathing
Spitting up blood
Spitting up phlegm
Wheezing

SKIN
Boils
Bruise easily
Dryness
Itching
Skin eruptions (rash)
Varicose Veins

GENITO-URINARY
Bed-wetting
Blood in urine
Frequent urination
Inability to control

Kidney infection or stones
Painful urination
Prostate trouble
Pus in urine

FOR WOMEN ONLY
Congested breasts
Cramps or backache
Excessive menstrual flow
Hot flashes
Irregular cycle
Menopausal symptoms
Painful menstruation
Vaginal discharge

Yes No Are you pregnant?

CIRCLE THE FOLLOWING CONDITIONS YOU HAVE HAD:

Alcoholism	Eczema	Malaria	Stroke
Anemia	Emphysema	Measles	Tuberculosis
Appendicitis	Epilepsy	Miscarriage	Ulcers
Arteriosclerosis	Fever Blisters	Multiple Sclerosis	Venereal Disease
Arthritis	Goiter	Mumps	Whooping Cough
Cancer	Heart Disease	Pleurisy	
Chorea	Gout	Pneumonia	
Cold Sores	HIV	Polio	
Diabetes	Influenza	Rheumatic Fever	
Diphtheria	Lumbago	Scarlet Fever	

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

The rating scales below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the *overall* impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed. **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.** A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Revised March 15, 1993

1. ***Family/Home Responsibilities.*** This category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. ***Recreation.*** This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. ***Social Activity.*** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. ***Occupation.*** This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. ***Self Care.*** This category includes activities which involve personal maintenance and independent daily living (eg, taking a shower, driving, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. ***Life-Support Activity.*** This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

TOTAL SCORE: ______ SIGNATURE: ______________________ DATE: ______________________

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317 Telephone: (602) 224-0220; Facsimile: (602) 224-0230

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): ______________________________ DATE: ____________

AGE: ________ DATE OF BIRTH: ______________ OCCUPATION: ______________________

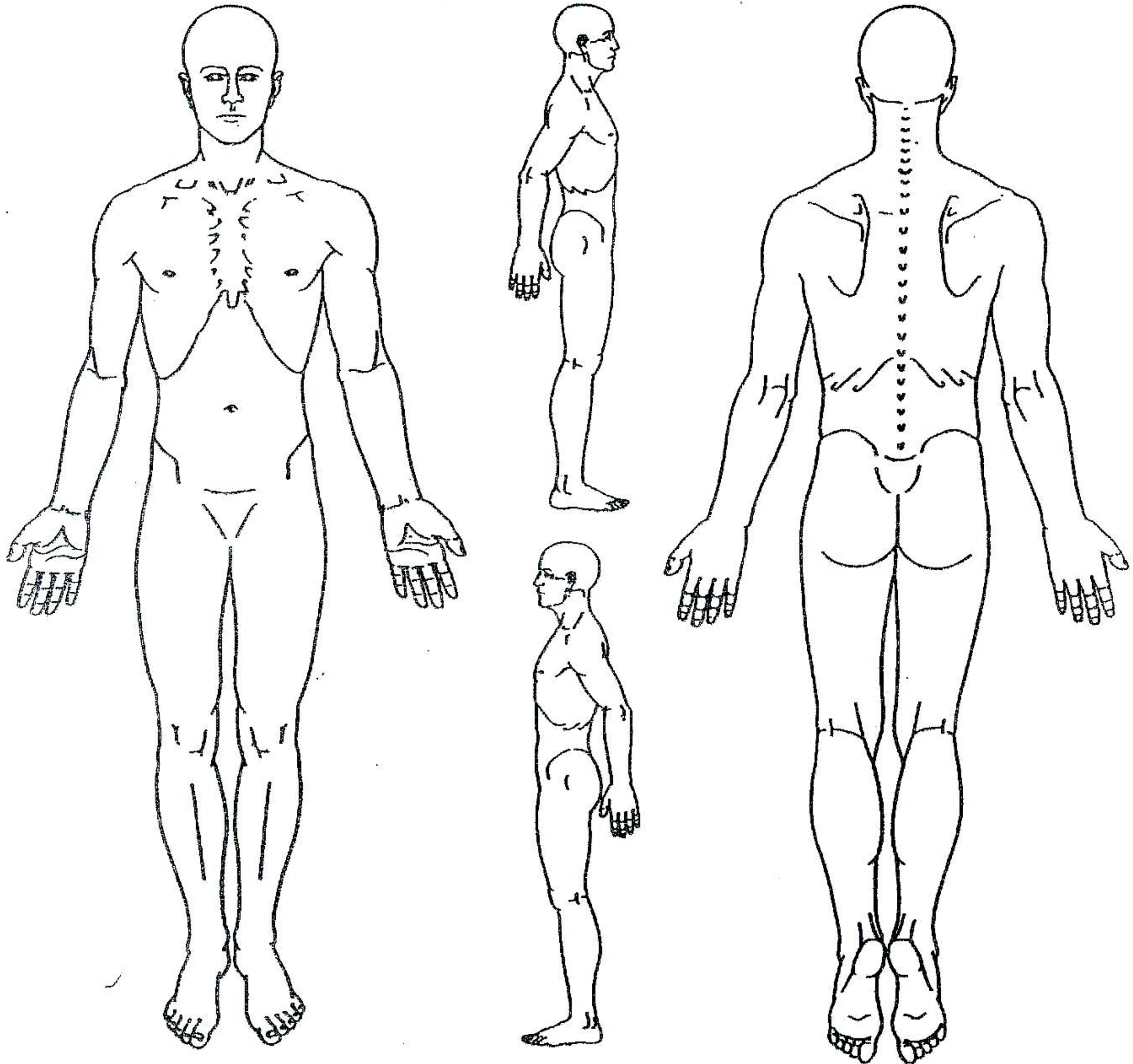
HOW LONG HAVE YOU HAD THIS PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF THIS PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY:	A=ACHE	B=BURNING	N=NUMBNESS
	P=PINS & NEEDLES	S=STABBING	O=OTHER



OVER PLEASE

For Doctor's Use:

Chief compliant (other than neck or low back pain): ______________________________

(For neck conditions use the Neck Pain Disability Index Questionnaire; for lower back conditions use the Roland-Morris or the Oswestry Low Back Pain Disability Questionnaire.)