HealthSource®
Chiropractic & Progressive Rehab™

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.
SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?
IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!

First Name _____ Middle _____ Last _____

Gender ❑ Male ❑ Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number ___ - ___ - ___ E-mail Address _____

Birthdate _____ Age _____ **Marital Status** S M W D

Employer _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Person responsible for this account _____

DOB of Insured Party _____

Social Security Number ___ - ___ - ___

Name of their employer _____ City _____

Employer Phone _____

Children–Names & Ages _____

_____

In case of emergency, whom should we contact? _____

Relationship of Emergency Contact: _____

Phone _____

FAMILY PHYSICIAN: _____

What is your primary complaint? _____

_____

IS THIS WORKMAN'S COMPENSATION? _____ **IS THIS PERSONAL INJURY?** _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

(Office use only)	Account Number	Date

HealthSource Chiropractic® Progressive Rehab & Wellness®

NAME: **DATE:** / / **Account#:**

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent ____Occasional

What caused the onset? _____

_____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE: / / Account#:**

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

Please place a checkmark by the condition that applies to you: **P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • **N** = Not Present • **PP** = If it has ever been present in the past • Do the same for your family
Family History Key: F = Father • **M** = Mother • **B** = Brother • **S** = Sister • **GF** = Grandfather • **GM** = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

List any allergies: _____

_____

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO

Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

❑ Allergic / Immunologic
❑ Constitutional
❑ Endocrine
❑ Gastrointestinal
❑ Genitourinary
❑ Integumentary
❑ Neurological
❑ Respiratory
❑ Cardiovascular
❑ Ears / Nose / Mouth
❑ Eyes
❑ All other system reviews negative
❑ Hematological / Lymphatic
❑ Musculoskeletal
❑ Psychiatric

Notes / Comments: _____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: _____ **DATE:** ____/____/____ **Account#:** _____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____

3. _____ Year_____ 4. _____ Year_____

5. _____ Year_____ 6. _____ Year_____

List any other key slips, falls or accidents you've had from childhood to present:	**Date**
1)	
2)	
3)	
4)	
5)	

What medications are you currently taking? (Include Date)	
1)	4)
2)	5)
3)	6)

Have you ever taken:	**YES**	**NO**	**YEAR**
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Known allergies to medications:

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: _____

_____

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

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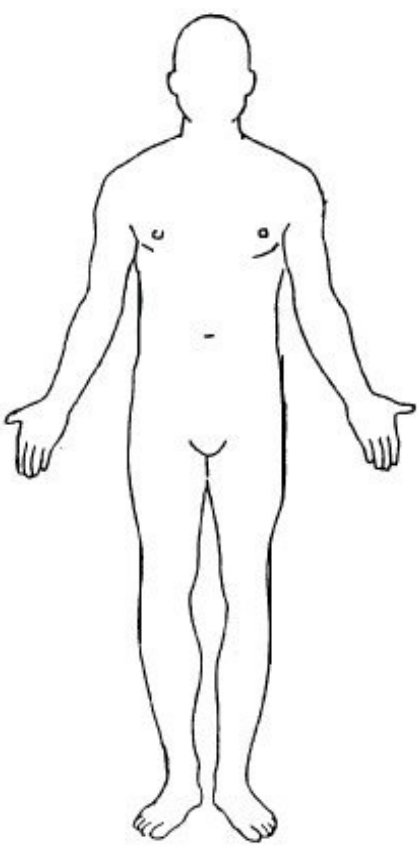
Pain Diagram

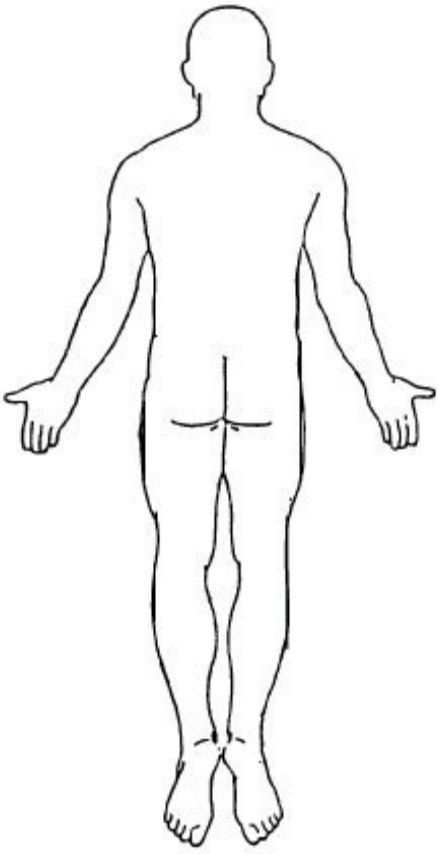
NAME: _____DATE: _____

Mark the areas on your body where you feel symptoms. Include all affected areas.
Use the appropriate symbol(s) listed below.

Dull Pain: dp	Sharp Pain: sp	Tingling: ti	Burning: bu	Stiff: stf
Aching: ac	Stabbing: st	Numb: nu	Throbbing: th	Sore: so

SEVERITY SCALE:
Please indicate severity with 0 being no problem to 10 being severe.





Other info/notes by patient
Notes:

_____

_____

_____

_____

_____

HealthSource®
Chiropractic & Progressive Rehab™

Authorization of X-Rays

I, _____, authorize New England Spinal Care, HealthSource of Norwood to take x-rays deemed necessary by the doctor.

FOR FEMALES

I,_____, certify, to the best of my knowledge, that I am not pregnant. I understand that x-rays could be hazardous to an unborn child. The date of my last menstruation was ____/____/_____

FOR MINORS

I, _____, as the legal guardian of, _____, authorize New England Spinal Care, HealthSource of Norwood to take any x-rays deemed necessary by the doctor.

X_____ _____
Patient or Parent Signature Date Signed

Note: Please mark unnecessary sections as Not Applicable (N/A) Thank You

106 Access Road
Norwood, MA 02062
Tel: 781-255-5565
Fax: 781-255-5564

Bell Autonomic Dysfunction Screening Criteria[i]

Name: _____ Date: _____

Please check all that apply:

❑	Headaches	❑	Un-refreshing sleep
❑	Lack of concentration	❑	Carbohydrates (sweets) cravings
❑	Fatigability	❑	Lightheadedness/dizziness
❑	Tinnitus (ringing of the ears)	❑	TMJ Syndrome
❑	Grinding of teeth	❑	Recurrent sinusitis
❑	Allergic reactions/runny nose	❑	Pharyngitis (sore throat)
❑	Post nasal drainage	❑	Cervical (neck) pain
❑	Crepitus (creaky joints)	❑	Spine pain (from top to bottom)
❑	Numbness/tingling of the extremities	❑	Unexplained chest pain
❑	Unexplained abdominal pain	❑	Unexplained hip, knee, ankle, or foot pain (especially on one side of the body)
❑	Palpitations	❑	Acid/peptic symptoms
❑	Irritable Bowel Syndrome	❑	PMS symptoms
❑	Irregular periods	❑	Hypertension
❑	Hyperglycemia	❑	Depression
❑	ADD symptoms	❑	Memory deficits
❑	Immune system dysfunction – frequent colds, flu, unexplained illnesses that are recurrent and enduring	❑	Scoliosis
❑	Widespread body pain	❑	Idiopathic diagnoses (“We’re not sure what’s wrong with you.”)

Total Number of Boxes Checked [ii]: _____

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[i] Reprinted with permission from Bruce Bell, M.D.

[ii] 10 or more criteria checked indicates brain stem/reticular formation pressure caused by a spinal misalignment. Please refer the patient to New England Spinal Care.

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____
PATIENT SIGNATURE INSURED'S SIGNATURE

_____
DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

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 HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic 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.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured/Guardian Date

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20___ to _____, 20___.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider, Phunkey Inc., and our Clinic's franchisor, HealthSource Chiropractic, Inc., of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by:_____
Printed Name – Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____
Printed Name – Clinic Representative

_____
Signature Date

For Internal Use:

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason:_____