

Name:			
Data			
Date:			

As a new patient in our office we want your experience to be the best it can be.

Please let us know if you have any questions.

REGULAR FEES:	
New Patient Examination Adjustment\$50 Soft Tissue work (Graston Te	\$100 - \$150 echnique®, and Therapeutic Exercises)\$45
We treat each patient on an individu	ial basis and offer care plans based on your needs.
The Doctor will be happy to go over	which fees will be applicable for you today.
PHASES OF CHIROPRACTIC C	CARE:
Initial intensive care:	Adjustments 2-3 times per week until symptom free.
Corrective healing:	Adjustments 1 time per week without re-lapse of symptoms.
Wellness:	Regular adjustment based on individual patient needs.
PAYMENT OPTIONS:	
☐ Insurance:	
•	of any kind, as a courtesy to you we can verify if there is coverage at patient co-payments / co-insurance apply.
Health Insurance Cor	npany (example: Blue Cross, Harvard Pilgrim)
With your approval and signate payment will be made direct	ature below, <b>Duxbury Wellness Center</b> will bill your insurance and y to our office.
☐ Patient Payment:	
	surance, we are happy to let you know about our special ill make it affordable for you to receive Chiropractic care.
Signature:	Date:



Signature: \_\_\_\_\_

Name:		
Date:		

Date: \_\_\_\_\_

Last Name:					Marit	al status:					
First Name:			Middle	:		Single /	Mar	/ Div /	/ Sep /	Wid	ow
Email:					Birth	Date:			Age:		Sex:
Address:				City:				State	•		
ZIP Code:		Cell Phone:			Hom	e Phone:					
Occupation:		Employer:									
Medical Care Infor	mation										
Do You Have a Family	y Doctor?:	☐ No	☐ Yes, Na	me of Do	ctor:						
Address:				City:			State	e:	ZIP Cod	de:	
Date of last Visit:	/ /			Date of I	ast exa	m: ,	/	/			
Have you had surgery	Have you had surgery ☐ Yes ☐ No If Yes, list date and reason for surgery:										
Present Illness /Co	onditions:										
☐ AIDS	☐ Cancer	☐ Heart Pro	oblem		☐ Mult	☐ Multiple Sclerosis [			☐ Spinal Disc Disease		
Allergies	☐ Cirrhosis/hepatiti	s High bloc	od pressure		☐ Pace	Pacemaker [		☐ Thyroid trouble			Epilepsy
☐ Anemia	Diabetes	☐ HIV/ARC			☐ Pros	ostate trouble		] Tuberc	Tuberculosis		
☐ Arthritis	☐ Dislocated joints	☐ Kidney tr	☐ Kidney trouble			neumatic fever		Ulcer			
☐ Asthma	☐ Diverticulitis	☐ Low Bloo	d Pressure		☐ Scoli	oliosis		☐ Polio			
☐ Bone fracture	☐ Hay Fever	☐ Mental/ E	Emotional Dif	ficulty	y Sinus trouble STD'S						
Other:		Medicatio	ns:								
Family History of I	llness:										
☐ AIDS	☐ Cancer	☐ Multiple	e Sclerosis	☐ Spinal	Disc Dis	ease	□s	TD'S			
Allergies	☐ Bone fracture	☐ Heart P	Problem	☐ Low Blood Pressure ☐ Sinus trou		uble Ulcer					
☐ Anemia	☐ Cirrhosis/hepatit	is HIV/AR	RC	☐ Mental/ Emotional Difficulty ☐ Epilepsy			□ P	olio			
☐ Arthritis	□ Diabetes	☐ High bl pressure	ood	☐ Prosta	Prostate trouble			□s	coliosis		
☐ Asthma	☐ Dislocated joints	S Kidney	trouble	Rheur	matic fev	/er	Т	uberculo	sis		iverticulitis
Type of Cancer:  Bre	east 🔲	Lung	Other:								
Alcohol? ☐ No ☐ Yes	Cigarettes?  Packs per da		Caffeine?  Drinks per o		S	Exercise? [ (circle one)			Hours pe lerate / St		
How did you hear	about us?			_							



Name:	_
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Date: \_\_\_\_\_

Please explain why a	re you here?
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<u> </u>						
	When did	this iss	sue/injury	begin?	/	/
Have you ever had similar concerns in the past?	□No □ Yes, If Yes, When?	/	/			
Have you ever seen a Chiropractor before?	□No □ Yes, If Yes, When?	/	/	Doctor:		

## Use diagrams to indicate pain or numbness.

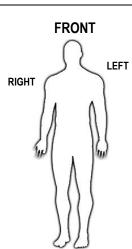
Draw an **X** for location of **pain** 

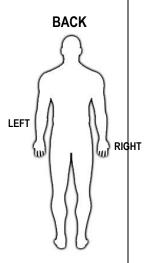
Circle O areas of **numbness** and/or **tingling** 

Use  $\rightarrow$  to show if **pain travels** from one area to another

## Rate your current level of pain with an X:

(0 = No Pain and 10 = Unbearable pain)





## ✓ all that apply:

My pain is: 🗆	Constant 💷	intermittent	□Sharp	□Dull	□Stabbing	□Burning	□Other_	
l evnerience:	□Numhness	Rurning	□Cramr	nina □	Tinalina □(	Other		

## **Symptoms/Concerns:** Please ✓ all that you have experienced in past 6 months.

Chest pain	Mental dullness	Shortness of breath	Ш	Headache
Irritability	Blurry vision	Pins/needles in hands		Rib pain
Back pain	Head feels 'heavy'	Pins/needles in feet		Dizzy
Confusion	Arm/shoulder pain	Pins/needles in arms		Fainting
Nervousness	Cold hands/feet	Pins/needles in legs		Neck pain
Constipation	Neck restriction	Pain while sitting		Tension
Depression	Loss of taste	Pain while standing		Ear ringing

Signature:	Date:
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