MINOR NAME: _____

GOOD THINGS TO KNOW

As a new patient in our office we want your experience here to be the best it can be and have found that people like to know what to expect. Our usual and customary fees are:

New Patient Examination……$75-$140
Adjustment……$50
Graston Technique, Myofascial Release and Therapeutic Exercises……$20

Having said that, here at our office we treat each patient on an individual basis and do offer care plans based on individual treatment and financial needs. The Doctor will be happy to go over which fees will be applicable for you today before she proceeds with your care.

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3 Phases of Chiropractic 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.

Health optimization/wellness: Regular adjustment based on individual patient needs.

- A re-examination will be done every 12th visit or 6 months of care (which ever comes 1st) to ensure you are in the correct phase of care, and if you experience any new symptoms or injuries.

☐ **INSURANCE**
If you have health insurance of any kind, as a courtesy to you we can verify exactly what your Chiropractic coverage is. Please indicate the name of your insurance company:

_____. With your approval and signature below, **Austin Chiropractic Center** will bill your insurance and payment will be made directly to our office.

☐ **NO INSURANCE**
If you do not have health insurance, we are happy to let you know about our special Affordable Savings Program, which will make it affordable for you to get Chiropractic care.

Parent/Guardian Signature: _____ **Date:** _____

DUXBURY WELLNESS

MINOR NAME:

First Name:	Last Name:	Middle:		
Email:	Birth date:	Age:	Sex:	
Address:	City:	State:		
ZIP Code:	Home Phone:	Cell Phone:		
Mothers Name:	Fathers Name:			

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Do You Have a Family Chiropractor?: ☐ No ☐ Yes, Name of Chiropractor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you had surgeries in the last 5 Years: ☐ Yes ☐ No	If yes, Last Surgery Date:		
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐
Other:					

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

List all Medications:	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

How did you hear about us?_____ Parent/Guardian:_____

DUXBURY WELLNESS

MINOR NAME: _____

Please explain why are you here?

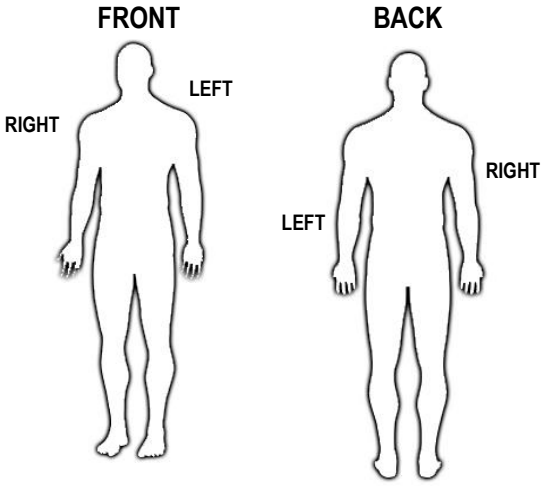
When did this issue/injury begin? / /
Have you ever had similar concerns in the past? ❑No ❑ Yes, If Yes, When? / /
Have you ever seen a Chiropractor before? ❑No ❑ Yes, If Yes, When? / / Doctor:

Use diagrams to indicate pain or numbness.

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

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

Use → 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)

|---|---|---|---|---|---|---|---|---|---|

0 5 10

✓ **all that apply.**

Symptoms are: ❑Constant ❑Intermittent

My pain is: ❑Dull ❑Sharp ❑Aching ❑Burning ❑Shooting ❑Tight/Stiff ❑Other_____

I experience: ❑Tingling ❑Numbness ❑Nausea ❑Anxiety ❑Depression ❑Fatigue

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

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

Parent/Guardian Signature: _____ **Date:** _____