Name:________________________

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……$140

Adjustment……$60

Soft Tissue work (Graston Technique®, and Therapeutic Exercises) ……$55

We treat each patient on an individual 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 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:

If you have health insurance of any kind, as a courtesy to you we can verify if there is coverage for Chiropractic care and what patient co-payments / co-insurance apply.

____

Health Insurance Company (example: Blue Cross, Harvard Pilgrim)

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

☐ Patient Payment:

If you do not have health insurance, we are happy to let you know about our special Care Savings Plans, which will make it affordable for you to receive Chiropractic care.

Signature: ________________________________ **Date:** ________________

Name: ________________________

Date: ______________

Last Name:		Marital status:		
First Name:	Middle:	Single / Mar / Div / Sep / Widow		
Email:		**Birth Date:**	**Age:**	**Sex:**
Address:	**City:**	**State:**		
ZIP Code:	**Cell Phone:**	**Home Phone:**		
Occupation:	**Employer:**			

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: / /		

Have you had surgery ☐ Yes ☐ No If Yes, list date and 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:	**Medications:**

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	☐ Diverticulitis

Type of Cancer: ☐ Breast ☐ Lung ☐ Other:

Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Signature: ________________________________ **Date:** _______________

Name:________________________

Date: ______________

Please explain why are you here?

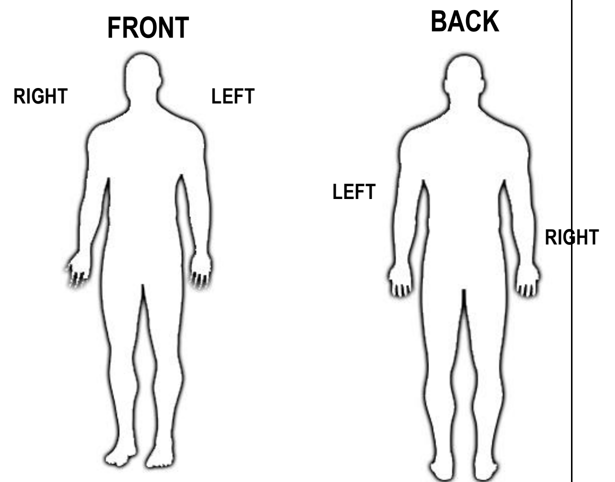
When did this issue/injury begin? / /
Have you ever had similar concerns in the past? ❑No ❑ Yes, If Yes, When? / /
Have you ever seen a Chiropractor before? ❑No ❑ Yes, If Yes, When? / / Doctor:

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

How did you hear about us? ______________________________

Signature: ____ **Date:** ____________________