



On Staff Chiropractic Physicians  
Winchester Hospital  
A Member of Beth Israel Lahey Health

Winchester Chiropractic Center  
300 Trade Center Suite 4460  
Woburn, MA 01801  
Telephone (781)933-5051 | Fax (781)933-5054  
winchesterchirocenter@gmail.com  
winchesterchirocenter.com

## WINCHESTER CHIROPRACTIC CENTER PATIENT INFORMATION – WORKER'S COMPENSATION

### PERSONAL INFORMATION

Name: \_\_\_\_\_  
First Name Middle Name Last Name

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State ZIP

Phone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_  
First Name Middle Name Last Name

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

### WORKERS' COMPENSATION INSURANCE INFORMATION

Date of Accident / Injury: \_\_\_\_\_ Employer: \_\_\_\_\_

WC Insurance Company: \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster: \_\_\_\_\_ Adjuster Telephone: \_\_\_\_\_

Your Attorney: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

Telephone: \_\_\_\_\_

### YOUR HEALTH INSURANCE INFORMATION

Name of Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Date of Injury: \_\_\_\_\_ (If applicable)



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## NEW PATIENT INTAKE

PERSONAL INFORMATION

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

Health Insurance: \_\_\_\_\_ Member ID: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Are you Pregnant?  Yes  No \_\_\_\_\_ # of weeks

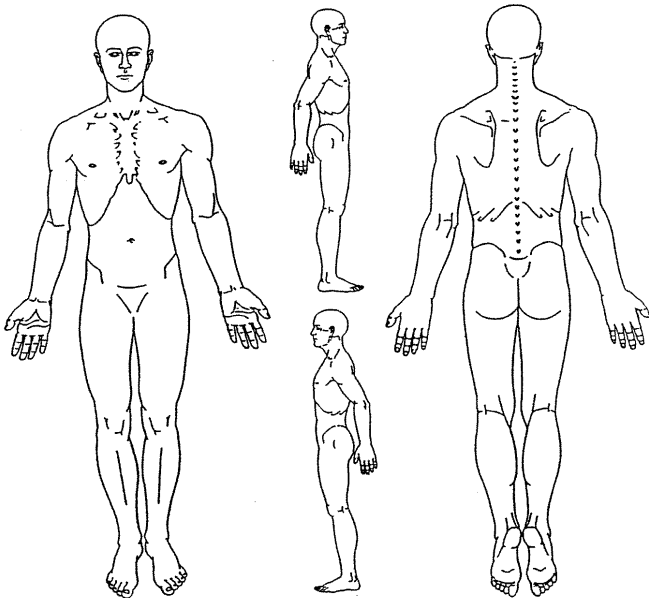
Dominant Hand:  L  R  Ambidextrous. Employer's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Were you referred to our office?  Yes  No If yes, who? \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS Reason for today's visit:



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please answer the following questions about your symptoms:

How often are your symptoms present?

0-25%  26-50%  51-75%  76-100% (Constant)

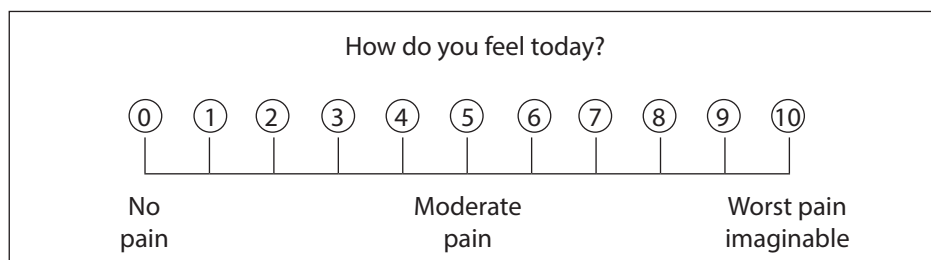
When did your symptoms begin? \_\_\_\_\_

\_\_\_\_\_

My problem has been:  Improving  Worsening  
 Staying the same

Any recent imaging?  Yes  No If yes, where? \_\_\_\_\_

\_\_\_\_\_



Please describe anything you do that improves your condition or worsens it:

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Please check off and describe how this problem interferes with your work and/or personal life

- Home Activities Affected: \_\_\_\_\_
- Work Activities Affected: \_\_\_\_\_
- Have you missed any work days?  Yes  No If yes, dates missed: \_\_\_\_\_
- Recreational Activities Affected: \_\_\_\_\_
- Rest or Sleep Affected:  Yes  No

### SURGICAL HISTORY

PLEASE LIST YOUR SURGICAL HISTORY INCLUDING DATES IF YOU KNOW THEM:

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Have you ever received Chiropractic care?  Yes  No If yes, please list the doctor's name, location of office and for what problems: \_\_\_\_\_

### MEDICATIONS

LIST MEDICATIONS INCLUDING VITAMINS YOU ARE CURRENTLY TAKING:

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### ALLERGIES

PLEASE LIST YOUR KNOWN ALLERGIES:

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### FAMILY HISTORY

IF YOU HAVE A FAMILY HISTORY OF ANY MEDICAL PROBLEMS, PLEASE LIST THEM:

EXAMPLE: Cancer, High blood pressure, Diabetes, Stroke, Clotting disorders, High cholesterol etc.

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### SOCIAL HISTORY

Marital Status:  Married  Single  Widowed  Divorced  Separated

Number of Children: \_\_\_\_\_ Name of spouse: \_\_\_\_\_

Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_ Do you drink?  Yes  No If yes, how much? \_\_\_\_\_

Do you exercise?  Yes  No If yes, how much? \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

Who is responsible for your bill?  I am  Spouse  My Employer  Insurance

Other: \_\_\_\_\_

Type of Insurance:  Worker's Comp.  Health  Automobile

Insurance Company Name & Address: \_\_\_\_\_

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Patient's  
Signature: \_\_\_\_\_

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



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## REVIEW OF SYSTEMS

Please mark **P** for in the past, **C** for Currently have

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Impotence/Sexual Dysfun       |
| <input type="checkbox"/> Stroke                             | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Loss of Bowel/Bladder Control |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Digestive Problems            |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Diarrhea/Constipation         |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Menopausal Problem            |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Facial Drooping        | <input type="checkbox"/> Hepatitis (A, B, C)           |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Bleeding Disorder             |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Numbness of Face       | <input type="checkbox"/> Ulcers                        |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Heartburn                     |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Heart Problems                |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | <input type="checkbox"/> Slurred Speech         | <input type="checkbox"/> High Blood Pressure           |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes     | <input type="checkbox"/> Double Vision          | <input type="checkbox"/> Low Blood Pressure            |
| <input type="checkbox"/> Pregnant (Now)                     | <input type="checkbox"/> Blurred Vision         | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Frequent Colds/Flu                 | <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Difficulty Breathing          |
| <input type="checkbox"/> Convulsions/Epilepsy               | <input type="checkbox"/> Hearing Loss           | <input type="checkbox"/> Lung Problems                 |
| <input type="checkbox"/> Tremors                            | <input type="checkbox"/> Depression             | <input type="checkbox"/> Kidney Trouble                |
| <input type="checkbox"/> Chest Pain                         | <input type="checkbox"/> Irritable              | <input type="checkbox"/> Gallbladder Trouble           |
| <input type="checkbox"/> Shortness of breath                | <input type="checkbox"/> Mood Changes           |  |
| <input type="checkbox"/> Pain w/Cough/Sneeze                | <input type="checkbox"/> Eating Disorder        |  |
| <input type="checkbox"/> Foot or Knee Problems              | <input type="checkbox"/> Trouble Sleeping       |  |
| <input type="checkbox"/> Incontinence                       | <input type="checkbox"/> Prostate Problems      |  |
| <input type="checkbox"/> Cancer: If yes, what type _____    |   |  |



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## NECK DISABILITY INDEX

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday - life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present - day situation.

### SECTION 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### SECTION 2 - Personal Care

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed. I wash with difficulty and stay in bed.

### SECTION 3 - Lifting

- I can lift heavy weights without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### SECTION 4 - Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

### SECTION 5 - Headaches

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 6 - Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

### SECTION 7 - Work

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 8 - Driving

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

### SECTION 9 - Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hours.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

### SECTION 10 - Recreation

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

Patient Name: \_\_\_\_\_

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



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## THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CHECK THE ONCE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

### SECTION 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

### SECTION 2 - Personal Care

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

### SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

### SECTION 4 - Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

### SECTION 5 - Sitting

- I can sit in any chair as long as I like.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

### SECTION 6 - Standing

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

### SECTION 7 - Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than 1/4.
- Because of pain my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

### SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life, and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

### SECTION 9 - Travel

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

### SECTION 10 - Changing degree of pain

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_



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## INFORMED CONSENT

### REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

#### I have been informed of the following:

1. That the process of delivering a “Chiropractic Adjustment (manipulation)” may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment “Supportive Therapies” may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or ignition of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;
4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
5. I have been afforded ample opportunity for questions and answers; and
6. The condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

#### Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor (s) involved in my case;

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### CONSENT TO TREAT

I consent to be treated by the Chiropractor(s) and staff of Winchester Chiropractic Center.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Personal Representative

### ASSIGNMENT OF INSURANCE BENEFITS

I request payment of insurance and/or Medicare benefits be made on my behalf to (Corporation).

I understand all copayments are due on the date of service.

I understand I am financially responsible for any treatment or balances not paid by my insurance company.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Personal Representative

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Notice of Privacy Practices.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or Personal Representative

### CERTIFICATE & ASSIGNMENT

I certify that I, and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to the above named clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

### PAYMENT POLICY

The above named clinic may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any changes for professional services rendered by the above named clinic.

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





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## OFFICE APPOINTMENTS AND CANCELLATION POLICY

### **APPOINTMENTS**

Please arrive on time for appointments. The office does its best to stay on schedule and your cooperation is essential. If you are unable to attend, please reschedule as soon as possible and notify the office as soon as you are aware a change is needed.

### **CANCELLATION/NO SHOW POLICY**

This policy is to ensure that patients have access to care when needed and to avoid the added expenses to our office due to cancellations and no-shows. This policy is beneficial to both patient and doctor as it helps in keeping costs down and allows us to serve our patients efficiently and with the highest level of care and preserve the valuable time of all involved.

If you need to reschedule your appointment or cancel for any reason, please do so in a timely manner so that we may adjust our schedule to allow another patient to use that time slot.

If you fail to give 24 hours notice or do not call at all, we reserve the right to bill you for that time reserved for you. The Cancellation/No Show Fee is \$25.00 for a standard chiropractic visit or re-exam and \$50.00 for a new patient evaluation. We understand there may be unpredictable and unique circumstances that cannot be avoided. Please contact us to explain and discuss any situation which may cause you to cancel or reschedule.

By signing below, I confirm that I have read the above office policies and agree to adhere to them as an active patient of the Winchester Chiropractic Center.

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Signature

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Date



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## HIPAA PRIVACY AUTHORIZATION FORM

**Authorization for Use or Disclosure of Protected Health Information**

**(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

I \_\_\_\_\_, hereby authorize and request \_\_\_\_\_ to release my health information (PHI) to:

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 Woburn, MA 01801  
 Telephone (781)933-5051 | Fax (781)933-5054  
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In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I understand that I am entitled to a copy of Winchester Chiropractic Center’s Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website [www.winchesterchirocenter.com](http://www.winchesterchirocenter.com) or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today’s date at which time this authorization expires.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date