Northeastern
Chiropractic

160 Speen Street, Suite 201,
Framingham, MA 01701

Office: (508) 309-7445
Fax: (508) 309-7446

First Name _____Middle Initial ____ Last Name_____

Address Line _____

City _____ State _____ Zip Code _____

Gender: ☐ M ☐ F Date of Birth _____/_____/_____

Marital Status: ☐ Single ☐ Married

Occupation:_____Employer Name:_____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email _____

Emergency Contact Name _____ Relationship to Patient _____

Phone (_____) _____-_____

Is the condition due to an accident? ☐ Yes, (Please fill out additional form) ☐ No

How did you hear about us?:_____

Have you previously been treated by a chiropractor?: ☐ Yes ☐ No

If yes, name and city/state:_____

Who is your Primary Care Physician?: _____

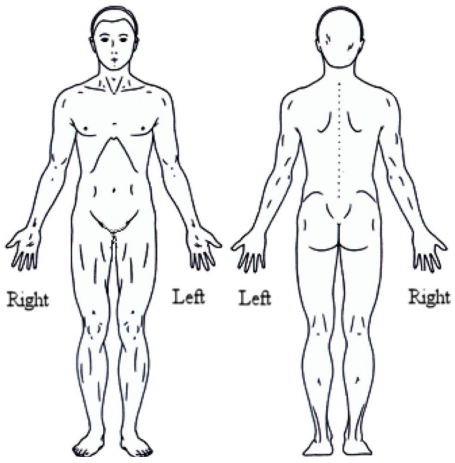
Address:_____

1. Reason(s) for visit:

1._____

2._____

2. Circle the area(s) on the drawings where you have pain/symptoms.



3. When did your problem begin?_____

4. How did your problem begin?

_____

_____

5. Has anything alleviated your problem, such as ice, heat, rest, sitting, standing, lying down, aspirin, medication?

_____

_____

6. Has anything aggravated your problem, such as lifting, bending, movement, coughing, sneezing?

_____

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 1 0 (Please circle)

8. How often do you experience your symptoms?

- □ Constantly (76-100% of the time)
- □ Frequently (51-75% of the time)
- □ Occasionally (26-50% of the time)
- □ Intermittently (1-25% of the time)

9. How would you describe the type of pain? (check all that apply)

- □ Dull
- □ Sharp
- □ Throbbing
- □ Burning
- □ Deep
- □ Aching
- □ Tingling
- □ Stabbing
- □ Cramping
- □ Numbness
- □ Radiating
- □ Stiffness
- □ Other:_____

10. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

11. Who else have you seen for your problem?

- □ Chiropractor
- □ Neurologist
- □ Primary Care Physician
- □ ER physician
- □ Orthopedist
- □ Massage Therapist
- □ Physical Therapist
- □ None
- □ Other_____

12. Do you currently or have you in the past done any of the following?

- □ Smoke. How much per day?_____
- □ Alcohol. What is the average consumption per week?_____
- □ Recreational Drugs
- □ Caffeinated Drinks. How many cups per day?_____

13. Indicate if you have any immediate family members with any of the following:

- □ Rheumatoid Arthritis
- □ Diabetes
- □ Lupus
- □ Alzheimer's Disease
- □ Heart Problems
- □ Cancer
- □ ALS

14. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column. Leave blank if doesn't pertain to you.

Past	Present	
□	□	AIDS/HIV
□	□	Alcoholism
□	□	Allergy
□	□	Angina (Heart Attack)
□	□	Anemia
□	□	Appendicitis
□	□	Arthritis
□	□	Asthma
□	□	Bleeding Disorder
□	□	Breast Lump
□	□	Bronchitis
□	□	Cancer(s)
□	□	Cataracts
□	□	Chemical Dependency
□	□	Chicken Pox
□	□	Diabetes

Past	Present	
□	□	Emphysema
□	□	Epilepsy
□	□	Fractures
□	□	Glaucoma
□	□	Goiter
□	□	Gout
□	□	Heart Disease
□	□	Hepatitis
□	□	Herniated Disk
□	□	High Blood Pressure
□	□	High Cholesterol
□	□	Osteoporosis

For Females Only

□	□	Pregnancy, #__
□	□	Endometriosis
□	□	Fibrocystic breasts

Past	Present	
□	□	Pacemaker
□	□	Prostates Problems
□	□	Prosthesis
□	□	Rheumatoid Arthritis
□	□	STD's
□	□	Stroke
□	□	Thyroid Problems
□	□	Tumors, Growth
□	□	Ulcers
□	□	Arteriosclerosis
□	□	Unexplained Dizziness

Other:_____
_____

□ □ Pelvic Inflammatory Disease

15. List any Allergies you may have, if any.

_____

16. List all prescription medications you are currently taking:

_____

17. List all of the over-the-counter medications you are currently taking:

_____

18. List all surgical procedures you have had:

_____

19. Have you ever been hospitalized?
□ No □ Yes
if yes, when / why: _____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

I understand that in the event of health insurance rejection of payment for services rendered, I am responsible for the full balance due and I will make a payment to Northeastern Chiropractic at the time of service and/or at time of insurance provider rejection.

Patient Signature _____ **Date**:_____

Parent or Legal Guardian's Signature (if patient is a minor) _____