Milton Chiropractic
& Rehabilitation, Inc.

BAY STATE
PHYSICAL THERAPY

General Patient Intake Form

File Number (Office Use) _________

Patient Information:

Today's Date ___________________________
Name ___________________________
I prefer to be called ___________________________
Address ___________________________
City/State ___________________________
ZIP ___________________________
Sex **Male** **Female**
Occupation ___________________________
Employer ___________________________

Home Phone___________________________
Cell Phone ___________________________
Preferred Contact **Home** **Cell**
Email ___________________________
Social Security No. ___________________________
Date of Birth ___________________________
Height ____' ____" Weight ______ lbs
Marital Status ___________________________
No of Children ___________________________

If minor, name of parent or guardian ___________________________
Who should we contact in case of an emergency? ___________________________
Relation ___________________________ Phone ___________________________
Primary Care Physician ___________________________ Phone ___________________________
» Is He/She within Harvard Vanguard Medical Group **YES** **NO**
How did you hear about our office? ___________________________
Have you ever been to a chiropractor / physical therapy before? **YES** **NO** Who?_______________

Insurance Information:

Insurance Company___________________________ Policy number ___________________________
Policy Holder's Name ___________________________ Date of Birth____________
Relation ___________________________

Reason for Visit:

This visit is as a result of *(Please circle)*: **work, sports, auto, trauma, or chronic**
Please describe your **PAIN** and its **LOCATION** ___________________________
____
____
Please describe what happened ___________________________
____
____
When did the symptoms begin? _____/_____/_____

Is the condition getting worse? **YES** **NO** **CONSTANT** **COMES & GOES**
Is your condition affecting your **WORK** **SLEEP** or **DAILY ROUTINE**?
Please explain ___________________________
Have you had this or similar conditions in the past? **YES** **NO**
Please explain ___________________________
Have you been treated by a medical physician for this condition? **YES** **NO**

Patient Signature ___________________________ **Date** _______________

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Health History

Please list all medications you are currently taking for this or any other health condition.

____
____
____

Please list any medical conditions that you currently have or have ever had. ____________________
____
____

Please list anything that you may be allergic to. ______________________________
____

Please list previous surgeries/treatments with dates. ______________________________
____

Please list any past serious accidents with dates. ______________________________
____

Please list any family medical health conditions? ______________________________
____

Do you: Take supplements or vitamins? **YES** **NO** Exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: ______/_____/_____

Do you smoke? **YES** **NO** How much? _____________ How long? _____________
Former Smoker, but have quit Years Since last Smoked ________________

Are you wearing: **HEEL LIFTS** **SOLE LIFTS** **INNER SOLES** **ARCH SUPPORTS** ?

For Women: Are you taking birth control? **YES** **NO**
Are you pregnant? **YES** **NO** Due Date? ___/___/___

Tests: (related to this problem)

Test	Have you had this test?	Date performed	Did you bring copy today?
X-ray	Y or N		Y or N
MRI	Y or N		Y or N
CT Scan	Y or N		Y or N
Bone Scan	Y or N		Y or N
EMG	Y or N		Y or N
Other:	Y or N		Y or N

Patient Signature_______________________________**DOB**____________**Date** ____________

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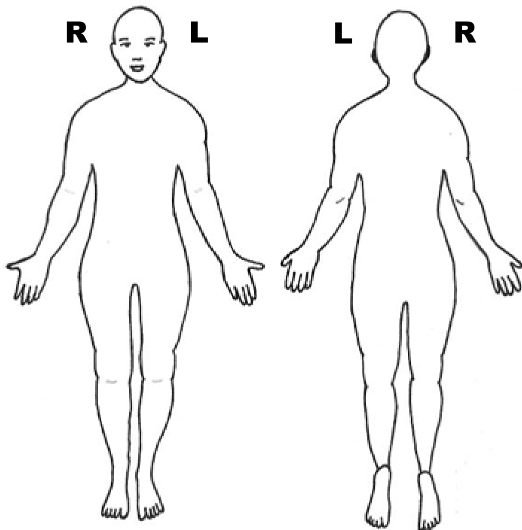
Please mark these drawings to show the location of your **CURRENT** symptoms and the type of symptoms you are experiencing.

Sharp Pain: ////// **Achy Pain:** ^^^^^ **Burning Pain:** XXXXX **Numbness:** 0000



Circle the number corresponding with the intensity of your symptoms. A "0" = **No Pain** where as a **"10" = most severe pain imaginable.**

Location:_________________________ 1 2 3 4 5 6 7 8 9 10

Location:_________________________ 1 2 3 4 5 6 7 8 9 10

Location:_________________________ 1 2 3 4 5 6 7 8 9 10

Location:_________________________ 1 2 3 4 5 6 7 8 9 10

Please Answer "YES" or "NO" As It Pertains to Your Health

CONSTITUTIONAL
Weight Loss Y N
Fatigue Y N
Fever Y N

EYES
Glasses/Contacts Y N
Eye Pain Y N
Double Vision Y N
Cataracts Y N

CARDIOVASCULAR
Murmur Y N
Chest Pain Y N
Palpitations Y N
Fainting/Spells Y N
Short of Breath Y N
Difficulty Lying Flat Y N
Swelling in Ankles Y N

ENDOCRINE
Loss of Hair Y N
Heat Intolerance Y N
Cold Intolerance Y N

PSYCHIATRIC
Anxiety Y N
Depression Y N
Mood Swings Y N
Difficulty Sleeping Y N

RESPIRATORY
Cough Y N
Coughing Blood Y N
Wheezing Y N
Chills Y N

GASTROINTEST
Heartburn/Reflux Y N
Nausea/Vomiting Y N
Constipation Y N
Change Bowel Mvts Y N
Diarrhea Y N
Jaundice Y N
Abdominal Pain Y N
Black/Bloody Bowel Mvts Y N

GENITOURINARY
Burning/Frequency Y N
Nighttime Y N
Blood in Urine Y N
Erectile Dysfunction Y N
Bladder Leakage Y N
Abnormal Leakage Y N

ALLERGIC
Hives/Eczema Y N
Hay Fever Y N

HEMATOLOGY/LYMPH
Bruise Easily Y N
Gums Bleed Easily Y N
Enlarged Glands Y N

MUSCLE/BONE
Joint Pain/Swelling Y N
Stiffness Y N
Muscle Pain Y N
Bone Pain Y N

SKIN
Rashes/Sores Y N
Lesions Y N
Itching/Burning Y N

NEUROLOGICAL
Loss of Strength Y N
Numbness Y N
Headaches Y N
Tremors Y N
Memory Loss Y N

FEMALES ONLY
Age Onset of Periods_______________
Periods Regular? Yes______No______
Age Onset of Menopause____________
Number of Pregnancies_____________

Patient Signature:_________________________________ **DOB**__________ **DATE**_____________

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Acknowledgement of Office Policies

The following are Milton Chiropractic and Bay State Physical Therapy's policies. Please read carefully AND INITIAL beside each section before signing the bottom, and be sure to ask any questions you might have before signing the document.

Appointment Scheduling. We at Milton Chiropractic and Bay State Physical Therapy are glad to accept insurance assignment on your behalf in handling payment for the care you receive. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying our office (emergencies considered), you may be dismissed from care and your file may be closed. _________

Consent for Treatment. I, the undersigned, give Milton Chiropractic and Bay State Physical Therapy my permission to evaluate and treat my injury as deemed reasonable and necessary. I further understand that with any diagnostic or therapeutic procedure there is always risk of injury or worsening of my condition on rare occasions (ie. increased pain, muscle spasm, rib injury, etc). Risk of such injury or complications from chiropractic treatments and physical therapy treatments are substantially lower than that associated with many medical procedures or medications given for the same symptoms. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment. _________

Assignment of Payment. I hereby **authorize** my insurance company and/or my attorney to pay direct to Milton Chiropractic & Rehabilitation and Bay State Physical Therapy any monies due on my account for professional services rendered. _________

Acknowledgement and Understanding. It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. _________

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) _________

Authorization to Release Information. I understand that Milton Chiropractic / Bay State Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Milton Chiropractic / Bay State Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. _________

Patient Requests for Records. I **authorize** the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to, exams, special tests, x-rays, or lab results to this office. _________

Ownership. I understand that Milton Chiropractic, Bay State Physical Therapy, Optimal Weight Loss and Massage Works! are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere. _________

I certify that I have read and understand all appointment and office policies listed above.

Name(print) ____________________Signature _________________________DOB_______Date ________