

# Welcome to MetroWest Spine Clinic & Spinal Decompression Center

Please fill out the following form in as much detail as possible. Please know that all information will be kept confidential.

## Patient Information

Patient name \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age: \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Gender:  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Single  Married  Partnered  Engaged  
 Separated  Divorced  Widowed  Minor  
How many children do you have? \_\_\_\_\_  
Please list any family members being treated here \_\_\_\_\_  
\_\_\_\_\_  
Occupation \_\_\_\_\_  
Employer/School \_\_\_\_\_  
How did you hear about us? (Friend)(Relative) (Internet)  
(Newspaper Ad) (Ins. Co.)(Other: \_\_\_\_\_)  
Insurance Co: \_\_\_\_\_  
Spouse's/Partner's name \_\_\_\_\_  
Who referred you? \_\_\_\_\_

## Contact Information

Home phone (\_\_\_\_\_) \_\_\_\_\_  
Cell phone (\_\_\_\_\_) \_\_\_\_\_  
Email address \_\_\_\_\_  
May we contact you via (please check for all applicable):  
 Home phone  Cell  Work phone  Email  
*In case of emergency please contact:*  
Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home phone (\_\_\_\_\_) \_\_\_\_\_  
Work/Other phone (\_\_\_\_\_) \_\_\_\_\_

## Mission Statement

**Our Passion is to share and celebrate in the healing journey of every family and individual who chooses to be lovingly served by us in a relaxed atmosphere.**

**We recognize health is an inherent state of well-being in mind, body and spirit. Our role is to remove any interference to health expression through optimal chiropractic and nutritional care supported by wellness education.**

**Our goal is to help create a world of maximized health and optimum human potential.**

### How Safe Is Chiropractic? How Do You Define Safe?

Years of training and the experience of giving thousands of adjustments make chiropractic care safe.

Even with clear warnings in the media and sun screening products, 6,000 people will die this year from skin cancer. Chiropractic care is much safer than getting a so-called "healthy" tan.

Many people take aspirin, ibuprofen, muscle relaxers, and other pain relief drugs. Besides covering up the symptoms and ignoring the underlying causes, 4,000 people will die this year from reactions to medically-prescribed drugs. Chiropractic care is much safer than drug therapy. Most people consider aspirin safe, yet a staggering number of people will die this year from its use. Chiropractic care is much safer.

While commercial airplane mishaps get a lot of publicity, estimates suggest that fewer than 300 people will die this year from flying on commercial aircraft. Chiropractic care is much safer than flying.

Every year, about 100 people get struck by lightning. You are more likely to get hit by lightning than to have a negative reaction to a chiropractic adjustment. Chiropractic is safer than being caught in a thunderstorm.

In fact, of the millions of patients who will benefit from chiropractic care this year, only a handful will have a newsworthy experience.

Is chiropractic care safe? Yes! Especially when compared with other forms of treatment.

## Patient Condition

What is your major complaint (*be as specific as possible*) \_\_\_\_\_  
\_\_\_\_\_  
When did your condition/symptoms/pain first appear? (*specific date, days ago, weeks ago, etc*) \_\_\_\_\_  
Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes  
Since the onset of your problem is it:  Getting worse  Staying the same  Slow to improve  
When is it worse?  Morning  Afternoon  Evening  
Does it interfere with:  Work  Sleep  Daily routines Other \_\_\_\_\_  
How long has it been since you really felt good? \_\_\_\_\_  
Other doctors seen for this condition:  MD  DC  DO  DDS  Other \_\_\_\_\_

## Patient Condition

Does the condition/symptom/pain radiate?  Yes  No

If yes, where and how frequently \_\_\_\_\_

How long/often does the radiation occur/last? \_\_\_\_\_

Do you have:  Numbness  Tingling  Weakness

Describe \_\_\_\_\_

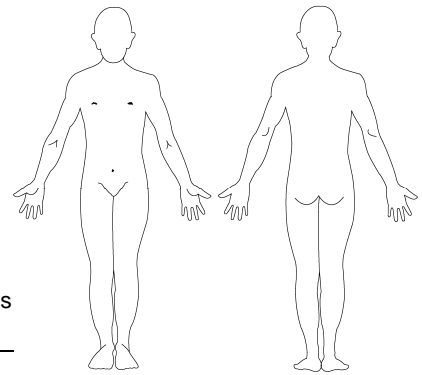
List and mark the severity of your condition/symptoms/pain on the scales below:

Body part \_\_\_\_\_ 0 (None) 5 (Severe) 10

Body part \_\_\_\_\_ 0 (None) 5 (Severe) 10

Type of Pain:  sharp  dull  aching  throbbing  numbness  
 shooting  burning  tingling  Other \_\_\_\_\_

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



What activities or positions aggravate your condition?

bending  coughing  getting up/down  driving  lifting  lying down  reaching  sitting  
 sneezing  standing  straining at stool  turning head  twisting  walking Other \_\_\_\_\_

What activities or positions relieve your condition?

heat  ice  lying down  medication  sitting  standing  stretching Other \_\_\_\_\_

Have you ever had this condition before?  Yes  No If yes, when? \_\_\_\_\_

Were you treated for this condition or a similar one before?  Yes  No If yes, when/by whom? \_\_\_\_\_

### Health History

Do you have any allergies? (food, contact, environment) \_\_\_\_\_

List any prescribed medications, over the counter medications, vitamins, herbs, and supplements \_\_\_\_\_

When was your last: Physical examination? \_\_\_\_\_ Blood/lab work? \_\_\_\_\_ X-ray study? \_\_\_\_\_

Injuries/Surgeries you've had and when? \_\_\_\_\_

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below.***

Ankylosing spondylitis  Yes  No  
Arthritis  Yes  No  
Asthma  Yes  No  
Bleeding disorder  Yes  No  
Blurred vision  Yes  No  
Bowel/Bladder problems  Yes  No  
Buzzing in ears  Yes  No  
Cancer  Yes  No  
Carpal tunnel  Yes  No  
Celiac disease (gluten)  Yes  No  
Chest pains  Yes  No  
Chronic fatigue  Yes  No  
Cold hands or feet  Yes  No  
Colitis/Diverticulitis  Yes  No  
Compression fractures  Yes  No  
Connective tissue issues  Yes  No  
COPD (bronchitis/emphy)  Yes  No

Cushing's disease  Yes  No  
Cystic medial necrosis  Yes  No  
Depression  Yes  No  
Diabetes  Yes  No  
Digestive/Bowel problems  Yes  No  
Dizziness or vertigo  Yes  No  
Fibromuscular dysplasia  Yes  No  
Fibromyalgia  Yes  No  
Fusions (spinal, joint, etc)  Yes  No  
Gout  Yes  No  
Heart disease  Yes  No  
Hepatitis (A, B, C, etc)  Yes  No  
Herpes  Yes  No  
High blood pressure  Yes  No  
Hip replacement  Yes  No  
HIV/AIDS  Yes  No  
Kidney disease  Yes  No

Knee surgery  Yes  No  
Liver disease  Yes  No  
Marfan syndrome  Yes  No  
Multiple sclerosis  Yes  No  
Osteoporosis/penia  Yes  No  
Parkinson's disease  Yes  No  
Prosthesis  Yes  No  
Rotator cuff problem  Yes  No  
STI/STD  Yes  No  
Shoulder surgery  Yes  No  
Spinal surgery  Yes  No  
Stroke/TIA  Yes  No  
Thyroid problems  Yes  No  
Tuberculosis  Yes  No  
Other \_\_\_\_\_  
Other \_\_\_\_\_  
Other \_\_\_\_\_

Are there any conditions that run in your family?  Yes  No If yes, what condition(s) and which family members? \_\_\_\_\_

## For Women Only

Do you currently or have you ever used birth control?  Yes  No If yes, what brand(s), dosage, when, and for how long? \_\_\_\_\_

Do you currently or have you ever taken hormone replacement medication?  Yes  No If yes, what brand(s), dosage, when, and for how long? \_\_\_\_\_

Are you currently pregnant, or do you think you may be pregnant?  Yes  No If yes, for how many weeks? \_\_\_\_\_

## Personal and Social Health History

How many hours per week do you typically work/attend school?  <20 hrs  20 hrs  30 hrs  40 hrs  40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc)? \_\_\_\_\_

Do you exercise?  Yes  No If yes, how often and what type? \_\_\_\_\_

Do you or does anyone else ever "crack" your neck/back/joints?  Yes  No If yes, how often and what body part(s)? \_\_\_\_\_

How would you rate your eating habits?  Excellent  Pretty good  Could be better  Needs improvement

Do you follow a specific nutritional program?  Yes  No If yes, what type? \_\_\_\_\_

Would you like help with your diet or have a nutritional program developed for you?  Yes  No

Habits?  Tobacco: Packs/Day \_\_\_\_\_  Alcohol: Drinks/Week \_\_\_\_\_  Caffeine: Cups/Ounces/Day \_\_\_\_\_

Other habits? \_\_\_\_\_

How well do you sleep?  Excellent  Pretty good  Restless  Can't Sleep

How many hours of sleep do you get daily? \_\_\_\_\_ and Do you feel well rested in the morning?  Yes  No

How is your energy overall?  Full power  Ok  Low  Sporadic/Generally fatigued

How do you feel your immune system is?  Strong  Ok  Low

In your own words, what do you think chiropractors do? \_\_\_\_\_

What do you hope to receive from our program? \_\_\_\_\_

Other than the current condition(s) for which you are here today, are there any other conditions that you have that you would like to have checked by the doctor?  Yes  No If yes, describe? \_\_\_\_\_

Please add any comments here \_\_\_\_\_

## Consent to Evaluation and Treatment

I hereby request and consent to the performance of an examination, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, on me (or the patient named below, for whom I am legally responsible) by Dr. Howard Austrager, D.C./Dr. Laurie Austrager, D.C. and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backdrop for Dr. Howard Austrager, D.C./Dr. Laurie Austrager, D.C. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

## Our Privacy Policy

The office of Dr. Howard Austrager, D.C./Dr. Laurie Austrager, D.C. are committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Dr. Howard Austrager, D.C./Dr. Laurie Austrager, D.C. may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

I hereby authorize and request my insurance company, third-party payors or my attorney to pay directly to Dr. Howard Austrager, D.C. and/or MetroWest Spine Clinic the amounts due on my claim for the services rendered to my dependant or me. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Printed Name of Patient or Guardian

\_\_\_\_\_  
Date

Thank you for completing our health care questionnaire