Welcome to MetroWest Spine Clinic

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? _____

Have you been to a chiropractor before? Y / N When? _____

_____

Occupation _____

Employer/School _____

How did you hear about us? (Friend)(Relative) (Internet)

(Facebook) (Ins. Co.)(Other:_____)

Insurance Co: _____

Spouse's/Partner's name _____

Who referred you? _____

Home phone (_____) _____

Cell phone (_____) _____

Email address _____

May we contact you via (please check for all applicable):

☐ Home phone ☐ Cell ☐ Text ☐ 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 you 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 _____

Does the condition/symptom/pain radiate (go down arm or leg)? ☐ 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:

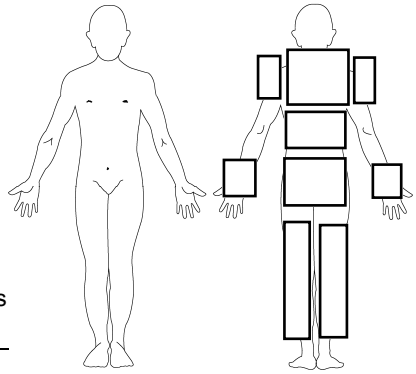
Body part _____ _____

0 (None) 5 (Severe) 10

Body part _____ _____

0 (None) 5 (Severe) 10

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



Type of Pain: ☐ sharp ☐ dull ☐ aching ☐ throbbing ☐ numbness ☐ shooting ☐ burning ☐ tingling ☐ Other _____

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 for all that apply.***

Ankylosing spondylitis	☐ Yes	Cushing's disease	☐ Yes	Knee surgery	☐ Yes
Arthritis	☐ Yes	Cystic medial necrosis	☐ Yes	Liver disease	☐ Yes
Asthma	☐ Yes	Depression	☐ Yes	Marfan syndrome	☐ Yes
Bleeding disorder	☐ Yes	Diabetes	☐ Yes	Multiple sclerosis	☐ Yes
Blurred vision	☐ Yes	Digestive/Bowel problems	☐ Yes	Osteoporosis/penia	☐ Yes
Bowel/Bladder problems	☐ Yes	Dizziness or vertigo	☐ Yes	Parkinson's disease	☐ Yes
Buzzing in ears	☐ Yes	Fibromuscular dysplasia	☐ Yes	Prosthesis	☐ Yes
Cancer	☐ Yes	Fibromyalgia	☐ Yes	Rotator cuff problem	☐ Yes
Carpal tunnel	☐ Yes	Fusions (spinal, joint, etc)	☐ Yes	STI/STD	☐ Yes
Celiac disease (gluten)	☐ Yes	Gout	☐ Yes	Shoulder surgery	☐ Yes
Chest pains	☐ Yes	Heart disease	☐ Yes	Spinal surgery	☐ Yes
Chronic fatigue	☐ Yes	Hepatitis (A, B, C, etc)	☐ Yes	Stroke/TIA	☐ Yes
Cold hands or feet	☐ Yes	Herpes	☐ Yes	Thyroid problems	☐ Yes
Colitis/Diverticulitis	☐ Yes	High blood pressure	☐ Yes	Tuberculosis	☐ Yes
Compression fractures	☐ Yes	Hip replacement	☐ Yes	Other	_____
Connective tissue issues	☐ Yes	HIV/AIDS	☐ Yes	Other	_____
COPD (bronchitis/emphy)	☐ Yes	Kidney disease	☐ Yes	Other	_____

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

_____

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

Metrowest Spine Clinic
Patient Financial Agreement

Patient Responsibilities

- You are responsible to provide us with accurate billing information for each family member at time of service.
- Our billing staff will do its best to verify your benefits with us and will provide you with assistance, but cannot resolve disputes between you are your insurance company.
- It is your responsibility to verify your own insurance benefits. This includes any deductible on your plan and what services, including x-rays, it affects, copay amounts and the number of services allowed by your plan.
- If we cannot verify your insurance coverage at the time of visit, we require a minimum of $50 deposit per visit.

Insurance Information

- It is your responsibility to ensure that we have accurate insurance information. Presenting an invalid or inactive insurance card will result in full payment by you.
- Medical insurance does not always cover the entire cost of your chiropractic/medical care. If we believe a service we offer is not covered by your insurance coverage, we will tell you. In some instances, however, if we do not learn that a service is not covered until after we submit the claim, you are responsible for payment if your insurance company refuses to pay for a service.
- It is important that we have accurate information on the guarantor. This is the person who is financially responsible for your bills.

Copayments

- Your insurance company may require you to pay your copay at the time of each visit or in advance, if prior arrangements have been made with Dr. Austrager.
- Your copay may be paid with cash, check, credit card, debit card or through 3rd party financing.
- If your check is returned a $25 returned check fee with be assessed
- If you do not have insurance coverage, you will be expected to pay at the time of your visit, unless other payment plans have been arranged with Dr. Austrager.

Deductibles

- Our office will make every effort to determine your deductible prior to service; however, it is your responsibility to understand any deductibles that may apply to you under your Insurance Policy.
- Should you fail to communicate the existence of a deductible, you will be liable for services not paid. In such a case, our billing department will send you a statement of the amount your insurance company has determined to your deductible and is owed by you.

Assignment and Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to pay any out of pocket expenses in full to Metrowest Spine Clinic within thirty days from the date of uncovered or denied services by my presented insurance coverage.

Signature:_____Date_____

Printed Name:_____