GREATER BOSTON
PERFORMANCE CARE

Patient Intake Form

1. Please complete the following information:

______________________________	XXXXXXXXXXXXX	_____/_____/_____
Name	Soc. Sec. #	Date of Birth

Student Status:_______FT_____PT Employment Status:_______FT_____PT Marital Status: S / M / D

______________________________	______________________	__________________
Address	City	State

______________________________	______________________________________
Phone	Email

2. How did you hear about our clinic? ____

3. Were you referred by anyone? If so, please name: ____________________________________

4. May we send you clinic updates? (ie. Upcoming seminars, newsletter) _______yes _______no

5. This information may be disclosed to and used by the following individual organization:

Greater Boston Performance Care
Dedham Health and Athletics Complex.
200 Boston Providence Hwy Suite #206
Dedham, MA 02026
Phone: (781) 251 9500

____

5. Who is responsible for this bill? _____

I will be paying today by: ❑ Cash ❑ Check ❑ Credit Card

I authorize Greater Boston Performance Care the release of any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to Greater Boston Performance Care. I authorize Greater Boston Performance Care to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. While Greater Boston Performance Care will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify the information above is true and correct to the best of my knowledge.

Signature:________________________ Date: _______________

Chief Complaint – Present Condition

1. When did your complaints and/ or symptoms begin? ____________________________
2. Describe your current injury or your current problem:____________________________
3. Please mark your symptoms on the diagram:

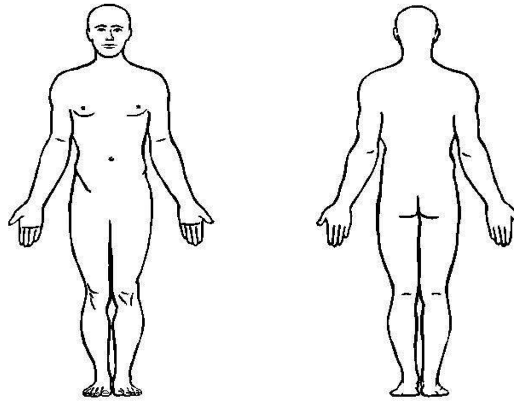
Aching – XXX

Burning – ###

Numbness – ///

Pins/ Needles – 000

Stabbing - ***



For Doctors Use

Rate your pain right now (mark as "N"), worst (mark as "W"), best (mark as "B")

0 1 2 3 4 5 6 7 8 9 10

no pain mild moderate severe very severe

Please check all present symptoms related to your current condition:

HEAD/ FACE

Base of skull	side/ temple	nausea	ear pain	throbbing	migraine
Front	ringing in ears	nose bleeds	eyelids heavy	top	doublle vision
Pressure	head feels heavy	eye pain	jaw pain	flushing	light sensitive
Blurry vision	HA affects vision	dizziness	sinus problems		

NECK

Weakness	spasms	pain on motion	limited motion	pain	swelliing
Lumps	throat tight	radiating pain	diff. swallowing	stiffness	

SHOULDER, ARM & HAND

Local pain	limb movement	arm radiation	pain from neck	swelling	cold hands
Weakness	neck radiation	numbness/ tingling		inability to raise arm	

Chief Complaint – Present Condittion

MID-BACK & LOWER BACK

Weakness	pain	spasms	rib pain	chest pain	stiffness
Swelling	pain on motion	limb motion	radiating pain		

HIPS, LEGS, KNEES and FEET

Local pain	radiating	from back	down leg	swelling	num**b**ness
Tingling	spasms	cramping	cold feet	weakness	pain **o**n motion

NERVES

Burning	numbness	tingling	tremor	dizziness	loss of balance
Loss of consciousness		coordination	twitching	difficulty with memory	
Seizures	generalized weakness				

SLEEP

Good	fair	poor	poor due to pain	deep burning pain
Wake often	difficulty falling asleeep			

FATIGUE

Rest during day	cannot get enough **r**est	intermittent fatigue	constant fatigue
Mental fatigue	physical fatigue	worse w/ exercise	

Doctor's Use Only

Present Condition Continued

Primary Medical Physician: ______________ Phone: __________

Primary Clinic Location: ______________

Do you have medical records that have been created or have you seen another doctor because of your current condition? Yes / No
If so, please list the doctors that have see you for your current complaint:

1. Name: ______________ Phone: ______________ City/ State: __________
2. Name: ______________ Phone: ______________ City/ State: __________
3. Name: ______________ Phone: ______________ City/ State: __________

Have you had any diagnostic tests performed by the aforementioned doctors or other doctors? Yes / No
If so, please check the tests that you have had performed:

MRI X-rays Lab Work Functional Testing Psychological Testing Electrodiagnostics Other: _______

Please Feel free to add any additional comments about your condition at this point in time that you feel would be important to your condition:

____

____

____

____

____

To help the doctor determine your needs, please indicate you specific interests:

Chiropractic Adjustments
Neurological Evaluation
Nutritional Counseling (recommendation)
Dietary Counseling (recommendation)
Exercise Consultation
Life Style Coaching

Doctors Use Only

Present Condition Continued

Have you ever been hospitalized? Yes / No

If so, where and when? ______________________________

Please list your surgeries:

Date	Type of Surgery	Results

Are you taking any medication? Yes / No

If yes, please complete table below:

Medication Name	Dosage	How Often	Duration of Medicaation

Are there any medications you have had an **a**llergic reaction or unpleasant side effects? ______________
____

Are you currently taking suppliments? Yes/No

If yes, please complete table below:

Supplement Name	Dosage	How Often	Duration of Supplement

Have you had an allergic reaction to the following?

Latex and rubber
Iodine or contrast dye
bee or wasp stings
influenza/ vaccination
adhesive tape
other: ______________________________

Do you have any food allergies? Yes / No

If yes, please list: ______________________________
____
____

Doctor's Use Only

Past Medical History

Systems Review

Please circle any of the following cond itions that apply to you, ***past or present***

Osteoporosis
Dislocated bones
Fractured bones
Bone infection
Herniated disc
Scoliosis
Osteoarthritis
Rheumatoid arthritis
Other arthritis
Gout
Ankylosing Spondylitis
Accidental fall
Mental or emotional disorder
Learning disability
Glaucoma
Heart palpitations
Swelling in legs or feet
Congestive heart failure
Chronic/ frequent cough
COPD
Coughing up blood
Colon problems
Gall bladder trouble
Liver disease
Stomach/ duodenal ulcer
Cirrhosis
Change in hat size
Change in skin mole
Acne
Hypertension
Seizures
Trouble concentrating
Paralysis
Twitching muscles
ADD/ ADHD
Macular degeneration
Ringing in ears
Sinus problems
Mouth sores
pregnancy
Irregular heart beats
Experience passing out
Skipped heart beats
Congenital heart disease
Shortness of breath w/ activity
Shortness of breath at rest
Polyps
Diverticulitis
Change in nails

Pain in your face
Temporal arteritis
Fainting spells
Blurred vision
Double vision
Muscle cramping
Tremors (shaking)
Eczema
Dermatitis
Dyslexia
Asberger's syndrome
Sleep apnea
Cataracts
Arrhythmia
Heart murmur
Artherosclerosis
Wheezing
Asthma
Gastric ulcers
Celiac Disease
Irritable bowel syndrome
Night sweats
Bruise easy
Psoriasis
Skin cancer
Loss of consciousness
Concussions
Head injury
Weak muscles of face
Autism
Bed wetting
Retinopathy
High cholesterol
Scarlet fever
Rheumatic fever
Emphysema
Bronchitis
Hepatitis
Chron's disease

Diabetes
Hyperthyroidism
Hypothyroidism
Shingles
Herpes
Warts
Psychological issues
Depression
Prostate problems

Anemia
Allergies
Anxiety
Phobias
HPV/ genital warts
Breast discharge
Vaginal discharge
Erectile dysfunction
Discharge from urethra
Gonorrhea
Bleeding disorder
Breast lumps/ soreness
Vascular disease
Vericose veins
Auto immune disease
Panic attacks
PTSD
OCD
Syphillis
Kidney problems/ diseas e
Kidney stone
Difficulty urinating
Feelings of urgency to urinate
Leg pain w/ walking
Blood clots
Frequent colds/ flu
Alcoholism
Cancer
Feelings of suicide
Eating disorders
Infrequent urination
Blood in urine
Painful urination
Awaken to urinate
Bladder infections
Other STD/VD
Venous insufficiency
HIV/ Aids
Pregnancy or chance of

Other: (please describe):
____
____
____
____
____
____
____

Informed Consent

I hereby authorize physicians and staff at Greater Boston Performance Care to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition of disease as a result of treatment with Greater Performance Care. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.
Specific risk possibilities associated with chiropractic care: Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. Soft-Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury or cause other minor joint ligament, tendon or other soft-tissue injury. Rib Injury – Manual adjusting to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as per-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk. Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member. Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments. Other problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

Having carefully read the "Informed Consent" (above), I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature: ____ Date: ______________

Parent or Guardian Signature: ____________________________________ Date: ______________

(please sign, print your name and relationship to the patient)

Patient's Right to File a Complaint:

If you believe any of your Privacy Rights have been violated, you can file a written complaint with our Privacy Officer. Your complaint must be filed within 180 days of when you know or should have known that the act occurred. In addition, you can also file a written complaint either of paper or electronically with the Office of Civil Rights. Please note that the privacy law prohibits our office from taking any regulatory actions against you.

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosures of protected health information by Pittsford Performance Care for treatment, payment, healthcare operations and additional uses listed above. I have reviewed, acknowledged, understand the content of the Notice of Privacy Practices and have had all my questions answered to my satisfaction.

Printed Patient Name ______________

Signature ______________________ Date ______________