GREATER BOSTON PERFORMANCE CARE

PATIENT INTAKE FORM

_____ _____

Name Date of Birth

_____ _____ _____

Street Address City State & Zip Code

_____ _____

Phone Email

How Did You Hear About Our Clinic? (Circle One)

Internet **Friend/Family** **Doctor** **Phys. Therapy** **Other:_____**

Were you referred by anyone? If so, please name: _____

Is this related to a Workers' Compensation claim or Auto Accident claim? If yes, please indicate which:

☐ **Workers' Comp** ☐ **Auto Accident**

I authorize the release of any medical or other information necessary for Greater Boston Performance Care 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 costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections if I should default on this agreement. In addition, if I issue a check that is returned by the bank for insufficient funds, I understand I will be charged a $30.00 fee for each returned check. While Greater Boston Performance Care will aide in the process 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 that the information above is true and accurate to the best of my knowledge.

_____ _____

Patient Signature Date

_____ _____

Signature of Parent or Guardian (if Patient under age 18) Date

Chief Complaint – Present Condition

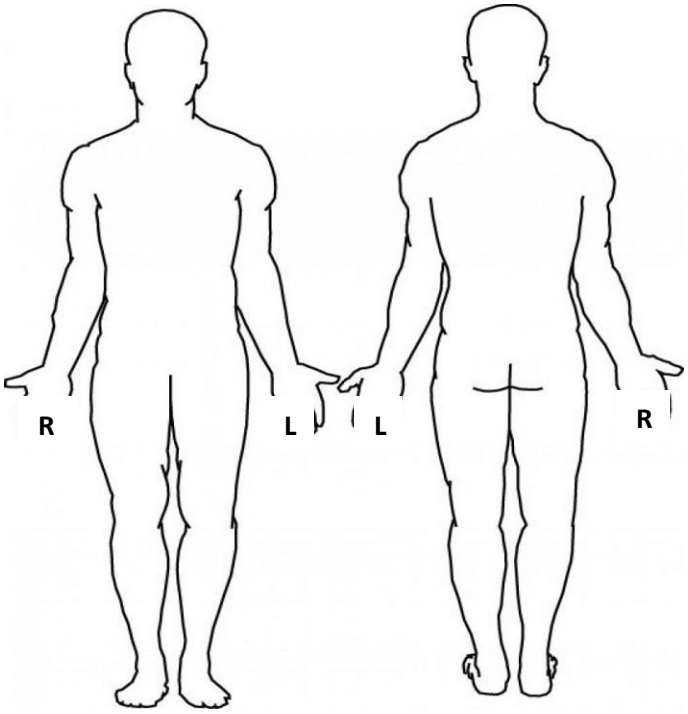
1. Describe your current injury or problem: _____

   _____

2. When did this injury occur or symptoms start? (Approx. Date)_____

3. Please use the guide to mark the area(s) of your symptoms:

Aching	**XXX**
Burning	**###**
Numbness	**ooo**
Pins/Needles	*******
Stabbing	**///**



On a scale of 0-10, with 0 being no pain and 10 being excruciating pain, please rate the following:

1. Your pain right now: _____
2. The worst this pain has been: _____
3. The best this pain has been: _____

Please circle all present symptoms related to your current condition:

HEAD/FACE

Pressure/ Headache	Head feels heavy	Nausea	Ear Ache	Throbbing Pain	Migraine
Blurry Vision	Double Vision	Eye Pain	Double Vision	Light Sensitivity	Jaw Pain
Ringing in ears	Flushing	Dizziness	Sinus Problems	Other:_____	

NECK:

Weakness	Spasms	Stiffness	Limited Motion	Swelling	Lumps
Difficulty Swallowing	Pain w Movement	Throat tight	Other:_____		

SHOULDER, ARM, HAND:

Local Pain	Weakness	Cold Hands	Limited Mobility	Numbness/Tingling
Pain w Movement	Unable to grip	Other: _____		

MID & LOWER BACK:

Weakness	Pain w Movement	Swelling	Spasms	Stiffness	Soreness

HIPS, LEGS, KNEES, FEET:

Local Pain	Radiating Pain	Swelling	Stiffness	Tingling	Numbness
Cramping	Spasms	Cold Feet	Weakness	Pain w/ Motion	
Other:_____					

NERVES:

Burning	Numbness	Tingling	Tremor	Dizziness	Loss of Balance
Poor Coordination	Twitching	Memory Problems		Loss of Consciousness	
Seizures	Generalized Weakness	Other: _____			

SLEEP & FATIGUE:

Trouble Falling Asleep	Trouble Staying Asleep	Mental Fatigue	Physical Fatigue	Can't get enough rest
Other: _____				

Please feel free to add any additional information about your condition that you feel is important for the doctor to know:_____

_____

_____

_____

_____

MEDICAL HISTORY

Primary Care Physician: _____

Please list any other doctors or specialists you have seen as a result of your current condition:

Name & Specialty:_____

Name & Specialty: _____

Name & Specialty:_____

Were you ever been hospitalized for your current condition? ☐ Yes ☐ No

If so, when & where? _____

Please circle any diagnostic tests you have had performed as a result of your current condition:

MRI **X-Ray** **Lab Work** **Functional Testing** **Psychological Testing** **Electrodiagnostics**

Other: _____

CURRENT MEDICATIONS		
Drug allergies: ❑ No ❑ Yes Please List:		
Latex allergies: ❑ No ❑ Yes		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

SURGERIES

Please list all surgeries you have had, whether or not they are relevant to this injury:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

SYSTEMS REVIEW

Please circle any of the following conditions that apply to you, *either* ***past or present***:

GENERAL

- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES

- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

NERVOUS SYSTEM

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES

- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

PSYCHIATRIC

- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Change in appetite
- ❑ Mood swings
- ❑ Anxiety
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations

EARS

- ❑ Ringing in ears
- ❑ Loss of hearing

EYES

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT

- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

SKIN

- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD

- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER

- ❑ Frequent or painful urination
- ❑ Blood in urine

HEART AND LUNGS

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Heart Murmur
- ❑ Arrythmia

OTHER:

INFORMED CONSENT

I hereby authorize physicians & staff at Greater Boston Performance Care to treat my condition as they deem appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I understand that while chiropractic care is remarkably safe, there are potential risks in the delivery of treatment.
Specific risk possibilities associated with chiropractic care include: 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 minor joint ligament, tendon or other soft-tissue injury. Rib Injury- Manual adjustments 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 preformed 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, it should be reported to GBPC. Stroke- A 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 5million upper cervical adjustments. Other Risks- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to GBPC promptly.
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot guarantee a cure for any symptom or condition of disease as a result of treatment with Greater Boston Performance Care. An attempt to provide the very best care is GBPC's goal, and if the results are not acceptable, GBPC will refer another provider for further assistance.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If Patient is under the age of 18)

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 Greater Boston Performance Care for treatment, payment, health care operations and additional uses listed above. I have reviewed, understood, and acknowledged the content of the Notice of Privacy Practices and have had all my questions answered to my satisfaction.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If Patient is under the age of 18)