FIRESTONE
CHIROPRACTIC & WELLNESS

400 W Cummings Park
Suite 5450
Woburn, MA 01801

Tel: 781-281-1086
Fax: 781-281-1843
info@firestonechiroandwellness.com

Confidential Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell Phone: _____ Email: _____

Gender: _____ D.O.B.:_____/_____/_____ SSN:_____/_____/_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Partner

Children: ☐Yes ☐No If Yes, How Many? _____ ☐Pregnant If so, how many weeks? _____

Emergency Contact Name and Phone: _____

Primary Care Physician Name and Phone:_____

How did you hear about us? _____

Confidential Employment Information

Occupation: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Status: ☐Full Time ☐Part Time ☐Retired

Condition Information

Have you been to a Chiropractor before? ☐Y ☐N Experience: ☐Positive ☐Negative

Have you had ever had massage therapy before? ☐Y ☐N Experience: ☐Positive ☐Negative

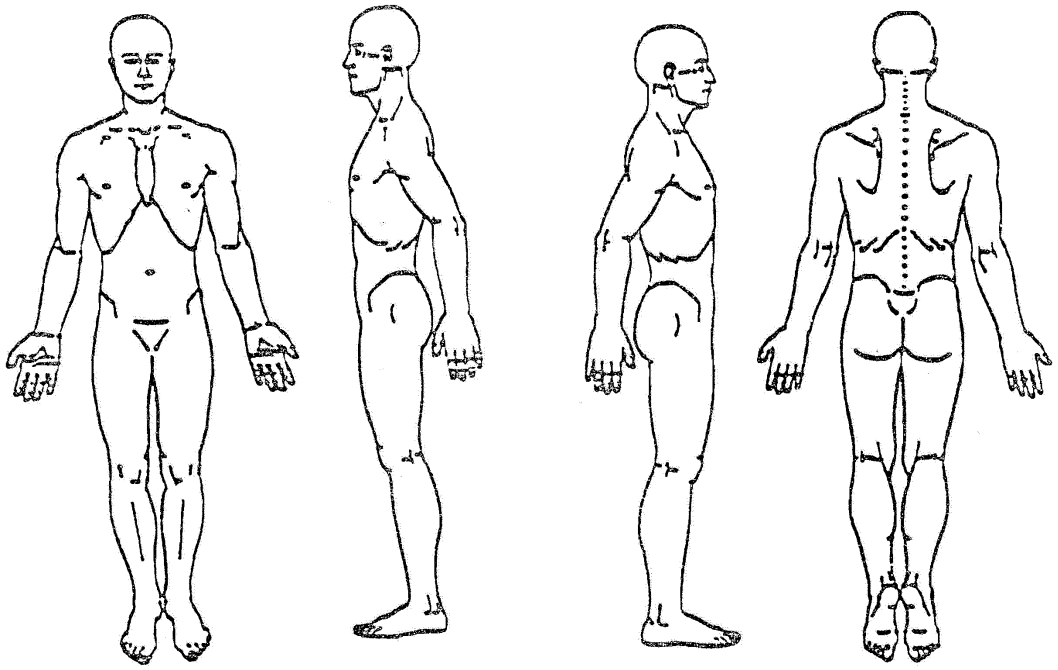
Please describe your current condition and any symptoms you are suffering from and mark the diagram below using the symbols at the right.

_____

_____

_____

_____



Aching.....A
Dull.....D
Sharp.....SP
Shooting.....SH
Stabbing.....ST
Burning.....B
Numbness.....N
Tingling.....T

Left Side Right Side

How long have you had this condition? _____

How did the condition start? _____

What aggravates it? _____

What relieves it? _____

Does it radiate? ☐Y ☐N If so, where does it travel? _____

Have you had similar conditions in the past? ☐Y ☐N

How frequently do you experience this type of condition?

☐Constantly 76-100% ☐Frequently 51-75% ☐Occasionally 26-50% ☐Rarely 0-25%

Is the condition changing? ☐Getting better ☐Getting Worse ☐Unchanged

Rate the intensity of your condition: 0-10 (0 = none, 10 = severe)

At its worst: _____ /10 At its best: _____ /10 Today: _____ /10

Is your sleep interrupted? ☐Y ☐N

Has this condition interfered with your daily activities? ☐Y ☐N

Have you seen any other health care provider for this problem? ☐Y ☐N

If Yes, which health care provider? _____

Medical History

Please indicate if any of the following apply to you (currently or in the past) or your immediate family members. (C = Currently P = Past F = Family Members)

___ Alcoholism
___ Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Bleeding/Bruising
___ Blood Pressure – Hi or Low
___ Bursitis
___ Cancer
___ Cardiac Issues
___ Circulation Issues
___ Contact Lenses
___ Dementia
___ Depression
___ Diabetes
___ Digestive Issues
___ Dizziness/Fainting
___ Endocrine Issues
___ Epilepsy
___ Fibromyalgia
___ Headaches
___ Heart Disease
___ Hernia
___ High Cholesterol
___ Joint Problems
___ Kidney/Urinary
___ Liver/Gall Bladder
___ Multiple Sclerosis
___ Muscle Strain/Sprain
___ Neurological Issues
___ Osteoporosis
___ Pacemaker
___ Phlebitis/Blood Clots
___ Respiratory Issues
___ Seizures/Epilepsy
___ Sinus Issues
___ Skin Conditions
___ Stress
___ Stroke
___ Trauma
___ Tumors
___ Ulcers
___ Varicose Veins
___ Vertebral/Disc Problems
___ Other
_____
_____

Alcohol: ☐Y ☐N If Yes, How Often? _____

Caffeine: ☐Y ☐N If Yes, How Often? _____

Tobacco: ☐Y ☐N If Yes, How Often? _____

Please describe your exercise habits, hobbies, and/or activities (including frequency per week)

_____

_____

Previous injuries (Auto accidents, slips/falls, sports, childhood)

_____

_____

_____

Previous hospitalizations or surgeries

_____

_____

Please list any medications & supplements that you currently take (or have taken in the past year)

_____

_____

Please List any other health related conditions

_____

_____

Do you have any known allergies that may affect your treatment (e.g. latex, massage lotions or oils, etc.)

_____

_____

Additional Comments: _____

_____

_____

Consent and Policies Agreement

Please read the statements below and initial them to confirm that you have read and understood them. If you have any questions, please ask.

_____ I grant permission to Firestone Chiropractic & Wellness to perform diagnostic testing and rendering of Chiropractic, Nutrition Counseling, and Massage Therapy services.

_____ I authorize Firestone Chiropractic & Wellness to collect my personal and medical information as documented above. This information is confidential and will not be disclosed to 3rd parties without my consent. I give permission for Firestone Chiropractic & Wellness to contact me and leave a message at any of the above telephone numbers.

_____ Firestone Chiropractic & Wellness maintains a professional environment and therefore reserves the right to cancel or terminate any session in the event the client's behavior is considered inappropriate. This includes, but is not limited to, intoxication, being under the influence of drugs, or sexual advances. Misbehavior of any sexual nature will result in immediate termination of the session and will be reported to the authorities. Payment for the service will be rendered in full. Termination of the session is at the discretion of the Doctor or therapist and does not require an explanation.

_____ I understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.

_____ Appointment Cancellation Policy: Please provide us 24-hour advance notice when cancelling an appointment, except in the case of emergency or sudden illness. Cancellations or missed appointments without 24-hour notice will result in a full charge for the appointment or session. **For chiropractic appointments, the fee is the private pay rate. For massage and nutrition appointments, the fee is the full price of the session.**

I have read the above statements and understand the policies of Firestone Chiropractic & Wellness.

Patient/Guardian Signature_____ Date: _____/_____/_____

Minor Name _____ Minor DOB: _____/_____/_____