Peter J. Stein, DC •• Chiropractic and Rehabilitation Therapies

WELCOME!

In order to provide you with the best possible care, please provide the information below.

PAYMENT INFORMATION

Unless other arrangements have been made, payment would be appreciated at the time that services are rendered.

PATIENT IDENTIFICATION

_____
Name

_____
Street

_____
City, State, and Zip

Contact numbers:
best #?

☐ Home: (____)_____

☐ Work: (____)_____

☐ Mobile: (____)_____

Email: _____

Contact in case of emergency:

Name: _____

*Telephone:(____)*_____

Occupation:_____

Male [ ] Female [ ]

Date of Birth:_____ Age:_____

Medicare ID no._____

Other insurance co.:_____
ID:_____

Who referred you to this office?

_____

May we thank them? [ ]*yes* [ ]*no*

Name of parent/guardian of Minor Patient:_____

Following your completion of these forms, a history and physical examination will be conducted, to further determine your health needs. In the event that your needs cannot be met here, this office will refer you to another health care provider, if appropriate. Your signature below will authorize payment to us by a third party, if applicable, for covered services we perform. You are ultimately responsible for payment of expenses related to your care in this office. This includes a fee for missed appointments, as well as for cancellations less than 12 hours in advance of the appointment time.

Please sign below to indicate your understanding of the above paragraph:

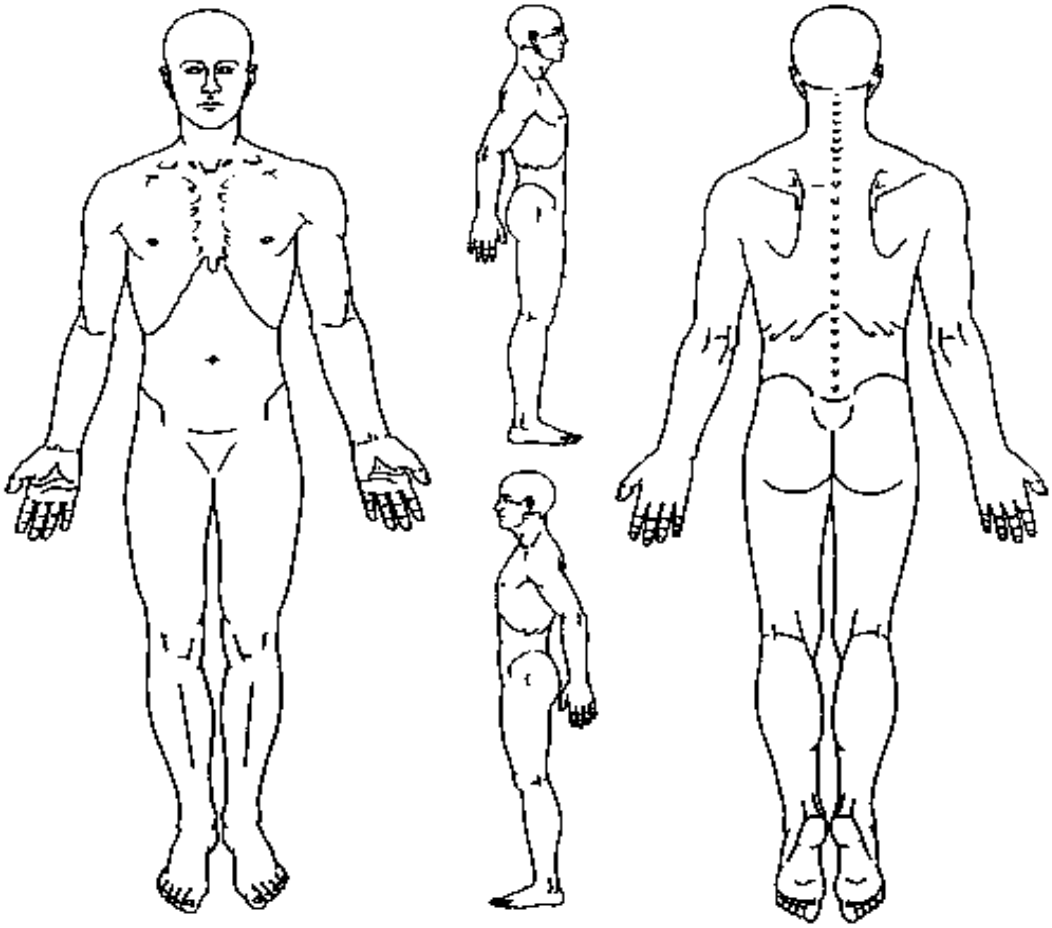
_____ _____
Signature Date

133 Brookline Ave. ••Boston, MA 02215 phone:(617) 232-3927 fax:(617) 421-6406

Name _____ ☐*Initial* ☐*Re-evaluation*

Please indicate areas where you experience pain, using the body outlines below. Please mark the quality of the pain, using the suggested code letters, or other indicators you prefer.

A = ache
B = burning
N = numbness
P = pins and needles
S = sharp/stabbing
X= other



Please mark your level of pain anywhere on the line below:

no pain — worst possible pain

HEALTH HISTORY

PATIENT NAME_____ BIRTHDATE____/____/_____

This history form provides us with information to help us meet all your healthcare needs. **This is a confidential part of your medical record.**

Today's date_____
Place of Birth_____
Highest level in school_____
Occupation_____
Previous occupations_____
Marital status_____
Hobbies_____
Exercise/recreation_____
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type & amount per week)_____
Caffeine (type & amount per day)_____
Recreational drugs (type & amount per day)_____
Usual weight_____My ideal weight_____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)_____
_____
_____ When was your last physical exam?_____
Primary doctor:_____Phone_____
address:_____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:
_____
_____
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs):
_____
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures/broken bones (include date occurred):
_____
_____
_____

Any history of family/partner violence?_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

PAST MEDICAL HISTORY

Do you have, or have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

measles	no	yes	migraine headaches	no	yes	bronchitis	no	yes
mumps	no	yes	tuberculosis	no	yes	multiple sclerosis	no	yes
chickenpox	no	yes	diabetes	no	yes	mitral valve prolapse	no	yes
whooping cough	no	yes	cancer	no	yes	stroke	no	yes
diphtheria	no	yes	polio	no	yes	hepatitis	no	yes
pneumonia	no	yes	glaucoma	no	yes	ulcer	no	yes
rheumatic fever	no	yes	hernia	no	yes	kidney disease	no	yes
heart disease	no	yes	reflux/GERD	no	yes	thyroid disease	no	yes
arthritis	no	yes	back trouble	no	yes	bleeding tendency	no	yes
sexually trans-mitted disease	no	yes	high/low blood pressure	no	yes	depression	no	yes
anemia	no	yes	asthma	no	yes	Any other disease/disorder? (please list):_____		
bladder infection	no	yes	hives/eczema	no	yes			
epilepsy	no	yes	AIDS or HIV+	no	yes			
			infectious mono	no	yes			

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

• I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

_____ ***OR*** _____

printed name *authorized personal representative*

_____ _____

signature *date*

_____

date