Chiropractic Associates of Worcester
Patient Health and Information Form

Patient Information:

Today's Date_____

Patient Name_____

Address_____

Zip code_____

Sex: Male____ Female_____

Age_____ Date of Birth_____

Social Security Number_____

Occupation_____
Employer_____

Single___ Married___ Widowed___ Divorced___

Spouse's Name_____

Who may we thank for referring you?_____

Phone Numbers:

Home_____

Cell/Work_____

E-mail address _____

Emergency Contact Information:
Name_____
Relationship_____

Phone_____

Accident Information:

Is this condition due to an accident? Yes No
Type of accident Auto____ Work___ Home____
Other_____

Date of accident_____

Who have you reported to:
Auto Ins____ Employer____ Work Comp____
Other_____

Attorney Name_____

Insurance Information

Please allow us to make a copy of your card

Insurance Company Name_____
Secondary Insurance_____

Subscriber Name and Birth Date_____
Relationship to Patient _____

Please sign "Assignment and Release" to allow us to receive payment from your insurance company for procedures performed.

Assignment and Release

I, the undersigned, certify that I (or my dependent) have chiropractic coverage with_____ insurance company and assign directly to Dr. Michael T. Finnegan all insurance benefits, if any, otherwise payable to me for services rendered. I under-stand 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.

_____

Signature

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Patient Condition

Reason for visit _____

When did symptoms start?_____
Is this condition getting progressively worse? Yes___ No___ Unknown___

Does anything make it better?_____ Worse_____

Rate the severity of your pain on a scale from 1 (being least pain) to 10 (being severe pain):
Today_____ When you feel best _____ When the pain is at it's worst_____

Type of pain you feel:

Sharp__ Dull__ Throbbing__ Numbness__ Aching__ Shooting__ Burning__ Tingling__
Cramping__ Stiffness__ Swelling__ Other_____

How often do you have this pain?_____Is it constant, or does it come and go? _____

Does it interfere with your: Work__ Sleep__ Daily Routine__ Recreation__

Please mark all that are painful to perform: Sitting__ Standing__ Walking__ Bending__ Lying Down__

What treatment, if any, have you received for your condition?
_____

Have you had x-rays, MRI, CT-scan, or any other diagnostic imaging done? _____
When?_____ Where?_____

Name of your Primary Care Physician: Dr. _____

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Please circle all that apply to you, add an approximate date:

AIDS/HIV		Insulin Dependent Diabetes		Herniated Disk		Pinched Nerve		Suicide Attempt	
Alcoholism		Non-Insulin Dependent Diabetes		Herpes		Pneumonia		Thyroid Problem	
Allergy Shots		Emphysema		High Cholesterol		Polio		Tonsillitis	
Anemia		Epilepsy		Kidney Disease		Prostate Problems		Tuberculosis	
Anorexia		Fibromyalgia		Liver Disease		Prosthesis		Tumors, Growths:	
Appendicitis		Fractures		Measles		Psychiatric Care		-Benign	
Arthritis		Glaucoma		Miscarriage		Rheumatoid Arthritis		-Malignant	
Asthma		Goiter		Mononucleosis		Rheumatic Fever		Typhoid Fever	
Bleeding Disorders		Gout		Multiple Sclerosis		Scarlet Fever		Ulcers	
Bronchitis		Headaches:		Mumps		Stroke		Whooping Cough	
Bulimia		Migraine		Osteopenia				Other, please list:	
Cancer		Tension		Osteoporosis					
Cataracts		Heart Disease		Pacemaker					
Chemical Dependency		Hepatitis		Parkinson's Disease					
Chicken Pox		Hernia							

EXERCISE:	**WORK ACTIVITY:**	**HABITS:**	Are you, or might you be, pregnant?
None	Sitting	Smoking Packs/Day_____	YES
Moderate	Standing	Alcohol Drinks/Week_____	NO
Daily	Light Labor	Caffeine Drinks Cups/Day_____	Due Date_____
Heavy	Heavy Labor	High Stress Level Reason_____	

INJURIES/SURGERIES YOU HAVE HAD: Please Describe Date

Falls: _____ _____

Head Injuries:_____ _____

Broken Bones:_____ _____

Dislocations:_____ _____

Surgeries:_____ _____

Concussions:_____ _____

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PLEASE LIST ALL:

MEDICATIONS	VITAMINS,MINERALS,HERBS	ALLERGIES