Welcome to
Newton Chiropractic and Wellness Centre

All new patients are requested to fill out this personal health history questionnaire. This data will assist the doctor to better understand your current situation. Once this is complete, you will have a one-on-one consultation with the doctor to discuss your health problems and to determine how we can best help you.

Confidential Health Record

PATIENT INFORMATION

*Name:*_____*Today's Date:*_____

*Address:*_____*City:*_____*State:*_____*ZIP:*_____

*Home Phone:*_____ *Cell Phone:* _____

E-Mail: _____ *Work Phone:* _____

*Occupation:*_____

*Date of Birth:*_____ *Age:*_____ *Gender:*_____

*Marital Status:*_____ *# of Children:* _____ *Ages of children(if any):* _____

How did you hear about Newton Chiropractic & Wellness Centre?

_____

_____

Part I: Your Current Health Status (what problem brought you here….)

1. *Please give your specific reasons for consulting this office:*

_____

_____

2. *When did this problem start?* _____

3. *Is this condition getting: ____ progressively worse, _____ constant, _____comes & goes, _____ better*

4. *Is this condition interfering with your: _____ work, _____sleep, _____daily routine, _____ other*

5. *If other, please explain* _____

6. *Have you consulted other doctors or health professionals for this problem? _____ Yes _____ No*

7. *If so, whom?* _____

In a published study of over 2,800 patients in Network Care, conducted within the Medical College at the University of California – Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below.
How do you hope to benefit from care in this office? ***Using the following scale, rate the benefits below:***
a) very important to me b) important to me c) not so important to me d) doesn't apply

_____ *Improvement of my physical symptoms*
_____ *Improvement of my emotional / mental symptoms*
_____ *Improvement of my ability to react or respond to stress*
_____ *Improvement in enjoyment of life and the ability to make constructive choices*
_____ *Overall improved quality of life*

Part II: Your Personal and Health History

1. *Have you ever injured your spine (neck, head, back, hips)?*
   a) *Date of most significant injury:* _____
   b) *What happened?* _____
   c) *Date of most recent injury:* _____
   d) *What happened?* _____

2. *Have you ever had your spine examined professionally? Yes _____ No _____*
   *If Yes, when and by whom?*_____

3. *Have you received chiropractic adjustments by a Doctor of Chiropractic? Yes _____ No _____*
   *If Yes, when?*_____ *How long were you receiving chiropractic adjustments?*_____
   *How often did you go?*_____
   *Do you know what type of adjustments the chiropractor performed, or what the technique(s) or methods he or she used?*_____
   *Were you pleased with his or her service?*_____

4. *What other forms of personal healing or growth have you explored? (ie. Bodywork/Massage, Yoga, Exercise, Dance, Meditation, Psychotherapy). Please give details:* _____

5. *Do you have frequent accidents? Yes _____ No _____*

6. *Approximately how many glasses of water do you drink daily?* _____

Part III: Your Medical History

1. *Are you currently under medical supervision? Yes _____ No _____*
   If yes, please explain: _____

2. *Are you currently taking any medication? Yes _____ No _____*
   If yes, please list: _____

3. *Have you ever been hospitalized? Yes _____ No _____ If yes, dates? _____*
   Why?_____
   _____

4. *Have you ever had surgery? Yes _____ No _____ If yes, dates? _____*
   Why? _____
   _____

Part IV: Stress Survey

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations caused by stress. Since these stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature we ask the following questions so we can better understand your current physical condition.

1. Birth History
Often people may not remember, but it is helpful data for us to know about your birth experience, as it is usually a stressful time for the family and the unborn / newborn child:

Are you aware of any falls, accidents or physical injury your mother may have had during pregnancy?
Yes ____ No _____ If yes, details: _____

Any complications to your delivery?_____
(ie. was your delivery drug induced, C section, breech, forceps or suction, cord around the neck)

Was your mother taking any drug prior to or during her pregnancy with you? Yes _____ No _____

Was she smoking or drinking? Yes _____ No _____ Which? _____

If you are a mother yourself, please describe if any of the above situations occurred during the pregnancy, labor and delivery of your own children: _____
_____
_____

2. General
Have you ever been knocked unconscious? Yes _____ No _____ Date(s) _____
Have you ever used crutches, a walker or cane? Yes _____ No _____ Date(s) _____
Have you ever broken any bones? Yes _____ No _____ Date(s) _____
Have you ever had any impacts, falls, or jolts? Yes _____ No _____ Date(s) _____
Injured your spine? Yes _____ No _____ Date(s) _____
Have you had extensive dental work performed? Yes _____ No _____ Date(s) _____
Orthodontic work? Yes _____ No _____ Date(s) _____

Describe any physical stresses to your normal day (ie: standing, mechanical work, heavy lifting,):
_____

3. Check off which ones apply in the appropriate box (Mild Moderate Extreme)
Falls from crib or carriage as a child ☐ ☐ ☐
Falls down or up steps ☐ ☐ ☐
Falls on ice ☐ ☐ ☐
Sports impacts ☐ ☐ ☐
Physical fight(s) ☐ ☐ ☐
Armed Services ☐ ☐ ☐

4. Sports / Leisure

I exercise: ☐daily ☐weekly ☐monthly ☐not yet

Were you, or are you active in any particular sports? Yes _____ No _____
If yes, which ones? _____
Have you been hurt in any of these activities? Yes _____ No _____ If yes, when? _____
Do you read for prolonged periods? Yes _____ No _____
Do you play a musical instrument? Yes _____ No _____ If yes, which ones? _____
Do you sit for long periods of time on the computer or watching TV? Yes _____ No _____

5. Automobile Accidents

Have you ever been involved in a vehicular collision? Yes _____ No _____ If yes, when? _____
What happened?_____

6. Chemical Stress:

Do you work with or are you exposed to chemicals, fumes, or other chemical irritants for prolonged periods? Yes _____ No _____ If so, describe: _____
Have you ever had? ☐ Spinal tap ☐ Spinal injections ☐ physiotherapy ☐extensive diagnostic x-rays ☐ Transfusions ☐ chemotherapy
Are you currently taking any prescription drugs? Yes _____ No _____
If yes, please describe which drug(s) and for what condition(s):

_____
Have you previously taken any medications regularly? Yes _____ No _____
If so, which medications? Dates taken? For what conditions?

_____
Do you consume? ☐ alcohol ☐ coffee ☐tobacco ☐artificial sweets ☐refined sugar ☐ other caffeinated beverages ☐ soft drinks
Do you take? ☐ vitamin supplements ☐ mineral supplements ☐herbs ☐homeopathic remedies

7. Emotional Stress - Please grade the following emotional stressors, both past and current, in your life:
Circle which: 0=none, 1=mild, 2=moderate, 3=extreme

	PAST				CURRENT			
Childhood stress	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
School stress	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Play or recreational	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Family Stress	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Stress of being sick	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Work	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Stress of Commuting	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Loss of loved one	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Change in lifestyle	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Change in vocation	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Abuse (physical, emotional, sexual)	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*
Other: _____	*0*	*1*	*2*	*3*	*0*	*1*	*2*	*3*

How do you grade your physical health? ☐ excellent ☐ good ☐ fair ☐ poor
How do you grade your emotional/mental health? ☐ excellent ☐ good ☐ fair ☐ poor
If you consider yourself ill, why do you feel ill?_____

_____
If you consider yourself well, why do you feel well? _____

_____
Anything else you feel is important for your doctor to know? _____

_____

_____

Newton Chiropractic and Wellness Centre

TERMS OF ACCEPTANCE

When a person seeks chiropractic health care, and when we accept a person for such care, it is essential that we work towards the same objective and understand the method that will be used to attain it. This will prevent any confusion or disappointment. The method used in this office is called Network Spinal Analysis.

***Network Spinal Analysis (NSA)** is a unique approach to chiropractic, and is a very gentle and precise application of techniques utilizing a variety of methods, thus the concept of "network care". The specific methods used are determined by each doctor's chiropractic and post graduate education, years of clinical experience in working with patients, and the patient's ability to receive the adjustment.*

- **A Network Spinal Analysis Session is called an *"Entrainment"* and is typically composed of two parts:**

  1. ***An Adjustment*:** *This is the specific application of forces used to facilitate the body's correction of the nerve interference and to restore normal function. This is done primarily by hand with a light touch and/or a dynamic thrust.*
  2. ***Therapeutic Exercises*:** *These are very specific bodily movements which will be performed with the help and direction of your chiropractor, to assist in correcting impairments in motion, flexibility and/or stability. By re-educating the muscles and joints using specific motions and/or breathing techniques your body will learn to better maintain correction.*

The object of any treatment plan formulated by one of our chiropractic doctor is to reduce and correct vertebral subluxation in order to assist people in expressing greater health.

- ***Vertebral Subluxation* is defined as:** *A misalignment of one or more of the vertebra in the spinal column which causes alteration of nerve function. This results in a decrease in the body's innate ability to express its maximum health.*

- ***Health* is defined as:** *A state of optimal physical, mental, and social well-being, not merely the absence of pain, disease or infirmity. Health is determined by a person's ability to perceive, adapt to, recover from and integrate life's experiences.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. If you desire advice, diagnoses, or treatment for specific symptoms or ailments, we recommend that you seek the services of a health care provider who specializes in that area.

Our Practice Objective: *To reduce and eliminate interference to the expression of the body's innate wisdom. Our method is to use NSA chiropractic entrainments to assist in the body's correction of vertebral subluxation. The human body functions well when it is clear of neurological interference.*

I undertake chiropractic care in this office for myself / myself and my family with the understanding of, and agreement with, the above explanation.

_____ _____

Patient's signature ***Date***

_____

Patient's name printed

NEWTON CHIROPRACTIC & WELLNESS CENTRE

PLEASE READ CAREFULLY BEFORE SIGNING – THANK YOU

PAYMENT POLICY

• All persons are required to pay-in-full for services rendered at time of visit unless otherwise arranged. You may pay by cash, check or charge.

• If you would like us to accept insurance assignment (accept your insurance as payment), you must first apply through our finance department. Once you have been accepted for assignment, as a courtesy to you we will submit your bills directly to your insurance company(s).

• If you would like us to assist you in verifying whether your insurance will cover some or all of your care here, please show the receptionist your health insurance card. The finance department will then advise you of your options.

• You are responsible for your deductible, co-payments and any unpaid balance on your account if your insurance company, for any reason, does not honor their commitment to you.

• We will assist you to understand your policy limitations, but we suggest that you communicate directly with your current carrier with any questions or concerns you have regarding your specific policy, including chiropractic benefits.

• Wellness Care Packages and Care Plans have been created to provide you with an affordable payment option. Please keep track of how many visits you have used.

CANCELLATION POLICY - (PLEASE READ CAREFULLY)
Please notify us as soon as possible if you are unable to keep your appointment. Our answering machine is on 24-hours a day.

Please help us to serve all members by providing us as much notice as possible.

Initials:	*Minimum 24-hour notice prior to a Chiropractic Appointment – Otherwise a **$25 fee** will be charged to your account.
_____	*Minimum 48-hour notice prior to an Acupuncture or Massage Appointment – Otherwise an **$89** fee will be charged to your account. (**$125 fee** will be charged for a 90-minute Massage appointment).

** Please note - We will do our best to fill your missed appointment. You can also give your space to a friend or family member.*

It is our commitment to serve as many people as we can, providing the highest quality care at an affordable rate.

In order to keep this commitment to the members of our practice, strict enforcement of the cancellation policy is necessary.

I have read, understand, and agree to the above policies.

_____ _____
Patient's signature ***Date***

I hereby assign any insurance payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance.

_____ _____
Patient's signature ***Date***

NEWTON CHIROPRACTIC & WELLNESS CENTRE

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Newton Chiropractic Centre / Newton Chiropractic & Wellness Centre.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print): _____

Signature: _____ Date: ___/___/_____

NEWTON CHIROPRACTIC & WELLNESS CENTRE

Insurance Verification of Chiropractic Benefits Checklist

Patient Name: _____ Date of Birth:_____
Name of Subscriber and Date of Birth (If different than above):
_____
Insurance Company: _____Policy/ID#:_____
Insurance Phone Number Called: _____
Name of insurance representative: _____
Date and Time of Call: _____ Call Reference #:_____

In or Out of Network Benefits

Note: Group NPI 1295747558. NCWC is only In Network with Blue Cross and Blue Shield (BCBS).

If you have BCBS, ask if you have In Network chiropractic benefits: ____YES ____NO
If you have another insurance, ask if you have Out of Network chiropractic benefits: ___YES ___NO
If no, we will assist you with a plan that best suits you, please call the office for assistance 617-964-3332.

Insurance Plan Effective Date: _____/_____/_____Termination Date: _____/_____/_____
What month and day does the benefit plan year restart: _____/_____/_____

Authorization/Referral

Do you need Pre-Authorization for Chiropractic visits? _____YES _____NO
If yes, at what visit do you need Authorization? _____
Do you need a Referral from your Primary Doctor (PCP) for Chiropractic Visits? _____YES _____NO

Copay, Coinsurance, and Deductibles

Do you have a Co-Pay? ____YES ____NO Co-Pay Amount: $_____
Do you have a Co-Insurance payment? ____YES ____NO Co-Insurance Amount:
$_____
Does your plan have a deductible that applies to chiropractic? ____YES ____NO (If No Skip to next section "Limitations", If yes record the amount below):
Amount of Individual Deductible $_____ How much has been met? $_____
Amount of Family Deductible $_____ How much has been met? $_____
Date of deductible reset:_____/_____/_____
Is there a maximum out of pocket per visit $_____
Is there a maximum out of pocket per year $_____

Limitations

Do you have any benefit limitations such as:

Maximum number of visits covered per year? Number of visits _____
If so, date of visit count reset:_____/_____/_____
How many visits have been used _____ how many visits are remaining _____
Do the visits need to be Medical Care/Medical Necessity? _____

Does you plan cover for maintenance or palliative care? *Palliative is defined as care for a chronic or recurring condition:*

_____

Note: Most plans do not cover palliative or maintenance care. Please ask if yours does. ***If they cover Palliative or maintenance care, we need this in writing.***

Codes

These are the codes we are most likely to use for your visits. We recommend you ask the insurance company if they are all covered:

New Patient Exam (Code: 99203)? ____YES ____NO Are there any limitations: _____
Re-Examination (Code: 99213)? ____YES ____NO Are there any limitations: _____
Manipulation (Code: 98940)? ____YES ____NO Are there any limitations: _____
Therapeutic Exercise (Code: 97110)? ____YES____NO Are there any limitations: _____

Please list any other insurance information you would like us to know:

_____
_____
_____
_____
_____