Health History

Westwood Family Chiropractic

Today's Date: _____

PERSONAL DATA

Name: _____ Age: _____ Date of Birth: _____
Both Parent's names: (if you are under 18) _____
Address: _____ City: _____ State/Zip: _____
Home phone: (_____) _____ Business Phone: (_____) _____
Cell Phone: (_____)_____ Cell Carrier: _____ SS#: _____
E-mail address: _____
Occupation: _____ Employer: _____
Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ L/W Spouse/Partners name: _____
Names & Ages of Children: _____
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Westwood Family Chiropractic can address for you?

_____

_____

Are these concerns affecting your quality of life?

Work	❑Y	❑ N	Driving:	❑Y	❑ N	Sleep:	❑Y	❑ N
School:	❑Y	❑ N	Walking:	❑Y	❑ N	Sitting:	❑Y	❑ N
Exercise/sports:	❑Y	❑ N	Eating:	❑Y	❑ N	Love life:	❑Y	❑ N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received chiropractic care? ❑Y ❑ N Name of D.C: _____
How long under care? ❑ _____days ❑ _____ weeks ❑ _____ months ❑ _____ years
Date of last visit: _____ Why did you stop care?_____

Have you consulted or do you regularly consult any of the providers below? *(check all that apply)*

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason: _____

FOR WOMEN

Are you pregnant? ❑Y ❑N Date of last menstrual period: _____
If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant**.
Signature: _____ Date: _____
If pregnant, Due Date: _____ Name of OBGYN or Midwife: _____

_____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center

Health, Vitality & Chiropractic Care

The primary system in the body which coordinates health is the **nerve system**. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called **vertebral subluxation**. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional and chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life and how they may be related to your present spinal, nerve and health status and whether they may have caused vertebral subluxations to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system.

Please check where and how you were birthed. *(If you do not know, please skip to next question)*

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps

❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y N	Loss of loved one	Y N	Abuse	Y N
Work or School	Y N	Divorce/separation	Y N	Financial	Y N
Lifestyle change	Y N	Parents divorce	Y N	Illness	Y N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑ Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N

If yes, please list: _____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter: _____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor

How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: *(Check all that apply)*

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

Finances

Westwood Family Chiropractic

Payment in full is expected on all FIRST VISIT services.

First Visit Fees: Comprehensive Exam: $100 X-Rays (if necessary): $175

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

Our Unique Approach to Finances at WFC

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. We utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary (as determined by your chiropractic evaluation at affordable fees.

Insurance

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with *itemized monthly statements for you to submit.* Please indicate below the type of statement you may need.

- ☐ Flex Plan or Health Savings Account Statement
- ☐ Insurance Statement

Have you had an Auto Accident, a Worker's Compensation Injury or a Personal Injury?

If yes, please provide us with the following information:

Date of Injury: _____ Have you been treated for injuries? ❑ Yes ❑ No

If yes, where? ❑ Emergency Room ❑ Primary Care ❑ Chiropractor

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy

NOTE: You will be required to pay for all services until we receive approval and payment from the insurance carrier. Once payment is received you will be reimbursed accordingly.

The information I have provided on this case history form is true and accurate to the best of my knowledge. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon. I give the doctors at WFC permission to render care to me today.

Name: (printed) _____ Date: _____

Signature: _____

Signature of Parent (for minor): _____

Dr. Peter Kevorkian | Dr. Patti Giuliano
781.769.2500 | 1446 High Street | Westwood MA, 02090

Consent Form

Westwood Family Chiropractic

PLEASE READ AND SIGN

1. A copy of Westwood Family Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on the website at www.westwoodfamilychiropractic.com.

2. I understand that most care is given in an open setting. Private rooms are available upon request.

3. I consent to receive communication from WFC in connection with my care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.

4. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to WFC. If I should withdraw my consent, I will notify the office in writing.

5. I consent to my testimonial being used in office and electronically with my first name and last initial only. If I should withdraw my consent, I will notify the office in writing.

6. I consent to my photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.

7. I agree that I am responsible to pay for all services I receive in this office.

Name: (printed) _____ Date: _____

Signature: _____

Signature of Parent: (for minor) _____

Please note below any withdrawal of consent to any of the above statements:

Signature: _____ Date: _____

Welcome to Westwood Family Chiropractic!