

**Assabet Valley Chiropractic**  
**1 Pleasant Street, Maynard, Mass. 01754**

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: M S W D Spouse's Name: \_\_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_ Occupation: \_\_\_\_\_ Referred By: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

**INSURANCE INFORMATION**

Are you covered by Medicare?  Yes  No If yes, Medicare ID# \_\_\_\_\_

Are you covered by Masshealth?  Yes  No If yes, Masshealth ID# \_\_\_\_\_

Do you have personal health insurance?  Yes  No Name of Insurer: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Plan or Group Policy #: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Preauthorization Phone#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Gender: Male Female Relationship to patient: Self Spouse Parent Other Employer/Group Name: \_\_\_\_\_

Do you have a referral from your primary care physician?  Yes  No If yes, referral#: \_\_\_\_\_

Name of referring physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is this condition the result of an automobile or work related accident?  Yes  No Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Auto or Worker's Compensation Insurer: \_\_\_\_\_ Claim#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Adjuster: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Name of Attorney: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Town \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

If this condition is related to an automobile accident or work related injury, additional information will be required. Please inform the front desk to ask for the additional form to fill out for your injury.

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**MEDICAL HISTORY**

Have you had previous chiropractic care?  Yes  No When? \_\_\_\_\_ Where? \_\_\_\_\_ Why? \_\_\_\_\_  
 Were x-rays taken? \_\_\_\_\_ Date of last x-ray, including dental: \_\_\_\_\_ Date of last physical exam \_\_\_\_\_  
 Present reason for contacting this office:  Pain, symptoms that are new and acute  Pain, symptoms that are chronic in nature  
 Preventive Health Care  Athletic Injury  Work related injury/condition  Automobile accident  other type of accident  
 What is your major complaint? \_\_\_\_\_

Other complaints \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_ What aggravates your condition? \_\_\_\_\_  
 Have you had this or similar conditions in the past? \_\_\_\_\_ Explain \_\_\_\_\_  
 Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes  
 Is this condition interfering with your:  work  sleep  daily routine  athletics  other, \_\_\_\_\_  
 How long has it been since you really felt good? \_\_\_\_\_  
 Other doctors who have treated this condition: \_\_\_\_\_  
 List surgical operations and years: \_\_\_\_\_

Women: Are you now, or do you have any reason to believe that you may be pregnant?  Yes  No

Medications you now take:  Pain killers, \_\_\_\_\_  Anti-inflammatory, \_\_\_\_\_  muscle relaxants, \_\_\_\_\_  
 Blood pressure meds, \_\_\_\_\_  Heart Meds., \_\_\_\_\_  Birth Control pills, \_\_\_\_\_  Insulin  
 Nutritional supplements, \_\_\_\_\_  Others, \_\_\_\_\_

Do you now smoke:  Yes  No  Cigarettes  Cigar  Pipe For how long? \_\_\_\_\_  
 Sleeping posture:  Side  Back  Stomach Age of mattress, \_\_\_\_\_ Comfortable?  Yes  No  Unsure  
 Do you wear?  Orthotics  Heel lifts  Arch supports  Inner soles  Sole lifts

Have you ever been in an automobile accident?  Yes  No If yes,  in the past year  past five years  over 5 years  
 Have you had any other type of personal injury or accident?  Yes  No If yes, describe \_\_\_\_\_

Please indicate if you are currently experiencing any of the following symptoms:

Neck pain	Mid-Back pain	Low back pain	Sleeping problems
Neck Stiff	Pain between shoulders	Numbness in toes	Nervousness
Headaches	Chest Pain	Pin & Needles in legs	Irritability
Ear pain	Rib pain	Feet feel cold	Cold sweats
Ears ringing	Shoulder pain	Constipation	Fatigue
Pins & needles in arm	Digestive disorders	Diarrhea	Fever
Arm pain	Stomach upset/nausea	Leg pain	Face flushed
Numbness in fingers	Painful/stiff joints	Hip pain	Loss of smell
Hands feel cold	Painful/stiff muscles	Knee pain	Loss of taste
Sinus trouble	Muscle weakness	Other _____	Shortness of breath
Dizziness	Head seems too heavy	Diabetes	Excessive thirst
Fainting	Depression	Heart problems	Excessive/poor appetite
Loss of Balance	Loss of Memory	Blood pressure problems	Menstrual irregularity
Confusion	Asthma	Neuritis	Cramping
Light bothers eyes	Allergies	Stomach ulcers	Bladder Problems
Tension	Prostate problems	Sexual dysfunction	Other, _____

Please circle the number that best describes your pain.

0      1      2      3      4      5      6      7      8      9      10  
 NONE      LITTLE      MEDIUM      MODERATE      SEVERE      EXTREME

Family History of heart problems, cancer, asthma, allergies, etc.... \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_