

CONFIDENTIAL PATIENT CASE HISTORY

My goal is to provide excellent chiropractic care to the community with a special focus on nutrition, exercise, and ergonomics.

EZRIN FAMILY CHIROPRACTIC

1464 Beacon St., Newton, MA 02468

Tel: (617) 969-0166

ezchiro@msn.com

DR. STUART EZRIN

website: www.drezrin.com

PRIVACY NOTICE: We are very concerned with protecting your privacy, especially in matters that concern your personal health information. We will not share your contact information or your health information with anyone without your permission. We may contact you about appointment reminders or other health information of interest to you. If we do not reach you by phone, a message will be left on your answering machine or voice mail unless you request otherwise in writing. In accordance with the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we are required to supply you with a printed copy of our privacy policies and procedures at your request. The document outlines the use and limitation of the disclosures of your health information and your rights as a patient. Our Privacy Policy is posted in our office and on our website, www.drezrin.com.

Date _____
Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ Would you like to receive our newsletter? yes no
Age _____ Date of Birth _____ # of Children _____
Marital Status: M S W D Occupation _____
Spouse's Name _____ Spouse's Daytime Phone _____
Referred by _____ Nearest Relative Name & Phone _____

HEALTH INFORMATION: Have you had previous chiropractic care? _____
What is your major complaint? _____

Other Complaints: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? yes no constant comes and goes

Is this condition interfering with your: work sleep daily routine Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition? _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills Tranquilizers Insulin

Birth control pills Others: _____

Age of mattress _____ Comfortable Uncomfortable Sleep on: Back Side Stomach # Pillows _____

Do you wear: Heal lifts Sole lifts Inner soles Arch supports

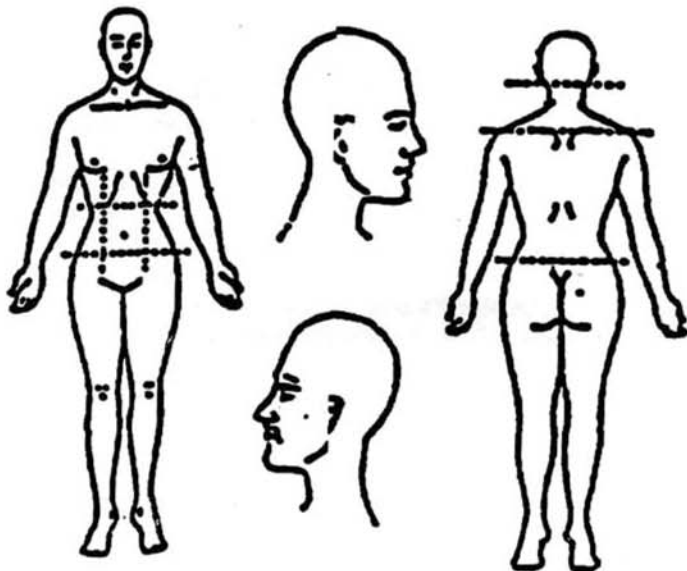
Have you been in an auto accident? Past year Past 5 years Over 5 years Never

Describe: _____

Have you had any other personal injury or accident? Past year Past 5 years Over 5 years Never

Describe: _____

Please mark your areas of pain on the figures below: **Date of last physical exam:** _____



Are you currently or have you ever suffered from:

	Currently	Occasional
Dizziness		
Backaches		
Heart Trouble		
Diabetes		
Arthritis		
Headaches		
Asthma		
Neuritis		
Digestive Disorders		
Nervousness		
Sinus Trouble		
Neck Pain		

On a scale of 1 through 10, with 10 representing excruciating pain and disability, and 1 representing the best you've ever felt, where on the scale below do you fit now? **Circle One:**

Best 1 2 3 4 5 6 7 8 9 10 Worst

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better understanding of your total health picture.

Name	Relation	Past & Present Health Conditions

INSURANCE INFORMATION

Is your condition due to an auto accident or job related injury? yes no

Do you have health insurance? yes no Insured's name _____

Name of Insurance Co. _____ Policy # _____

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS ARE MADE

Name of person responsible for payment _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I also give Dr. Stuart Ezrin power of attorney to endorse checks made out to me to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable, and any amounts owed after ninety days' time will be subject to an interest charge not to exceed 1.5% per month.

Patient's signature _____ Date _____

Guardian or spouse's signature _____ Required if patient is under 18.