

Wilmington Family Chiropractic

Dr. Stephen Jensen

7 Middlesex Avenue
Wilmington, MA 01887
Phone: (978) 658-7590

Personal Information

First _____ M _____ Last _____ Nickname _____ Date _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Gender M/F _____ Marital Status _____ Spouse _____
Date of Birth _____ Email Address: _____
Height: _____ Weight _____ Employed? Y N _____ Employer Name: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Children? Y N _____ If yes, number of children? _____ Ages of children: _____
Names of children: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
How did you hear about Wilmington Family Chiropractic? _____

Health Insurance Information

Do you have insurance coverage? ☐ Yes ☐ No
Who Is Responsible for payment/co-payment? ☐ Self ☐ Spouse ☐ Parent ☐ other _____
Insurance Carrier _____ Policy Number _____ Copay _____
Name of Insured, if not self _____ Birthdate of Insured _____ SS# _____
Insured's Employer _____ Address _____
Are you covered by any other insurance? ☐ Yes ☐ No
Insurance Carrier _____ Policy Number _____ Copayment _____

Auto Accident Insurance

Auto Insurance Carrier _____ Policy Number _____
Address _____ City _____ State _____ Zip _____
Insurance Contact _____ Insurance Co. Phone # _____
Date of Accident _____
Name of Insured _____ (whose car was it?)
Patient Relationship to the insured?? ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Reason for the Appointment

Describe your condition(s)/symptoms/pain _____ Date the condition occurred? _____

On a Scale of 1 - 10 with 10 being the worst, circle the pain you currently have:

1 2 3 4 5 6 7 8 9 10

Neck Pain

1 2 3 4 5 6 7 8 9 10

Mid Back Pain

1 2 3 4 5 6 7 8 9 10

Low Back Pain

1 2 3 4 5 6 7 8 9 10

Headaches

1 2 3 4 5 6 7 8 9 10

Shoulder Pain

1 2 3 4 5 6 7 8 9 10

Other Pain

(describe other pain and location) _____

Attorney Information

Attorney Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

Automobile Accident

DESCRIBE THE VEHICLE

Patient's Vehicle Type: <input type="checkbox"/> Bus <input type="checkbox"/> Van <input type="checkbox"/> Sport-utility <input type="checkbox"/> Sports car <input type="checkbox"/> Truck <input type="checkbox"/> Coupe <input type="checkbox"/> Station Wagon <input type="checkbox"/> Sedan <input type="checkbox"/> Pick-up truck	Vehicle Size: <input type="checkbox"/> Compact <input type="checkbox"/> Mini <input type="checkbox"/> Full-Size <input type="checkbox"/> Sub-compact <input type="checkbox"/> Light <input type="checkbox"/> Semi <input type="checkbox"/> Mid-Size	Position in vehicle: <input type="checkbox"/> Driver <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Front mid passenger <input type="checkbox"/> Rear mid passenger <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear right passenger
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DESCRIBE THE ACCIDENT

Action of patient vehicle: <input type="checkbox"/> Crossing intersection <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped for pedestrian <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Turning right <input type="checkbox"/> Turning left <input type="checkbox"/> Traveling speed limit <input type="checkbox"/> Faster than speed limit <input type="checkbox"/> Slower than speed limit	Patient's Vehicle was hit: <input type="checkbox"/> Head-on <input type="checkbox"/> On the left front <input type="checkbox"/> On the right front <input type="checkbox"/> On the left rear <input type="checkbox"/> On the right rear <input type="checkbox"/> Was rear-ended <input type="checkbox"/> Sideswiped on left <input type="checkbox"/> Sideswiped on right	Patient's Vehicle hit: <input type="checkbox"/> Other vehicle head-on <input type="checkbox"/> Left front of other veh. <input type="checkbox"/> Left rear of other veh. <input type="checkbox"/> Rt rear of other veh. <input type="checkbox"/> Rt front of other veh. <input type="checkbox"/> Rear-ended other veh. <input type="checkbox"/> Sideswiped other veh on left <input type="checkbox"/> Sideswiped other veh on right	Damage: <input type="checkbox"/> Complete <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate Damage to other Vehicle: <input type="checkbox"/> Complete <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate	Time of Day <input type="checkbox"/> Dawn <input type="checkbox"/> Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Night Visibility <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Good
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Patient's Vehicle was hit by: <input type="checkbox"/> A compact car <input type="checkbox"/> A pick-up truck <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A full-sized van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A mini-van <input type="checkbox"/> A semi-trailer <input type="checkbox"/> None of the above <input type="checkbox"/> A light truck <input type="checkbox"/>	Patient's Vehicle hit: <input type="checkbox"/> A compact car <input type="checkbox"/> A pick-up truck <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A full-sized van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A mini-van <input type="checkbox"/> A semi-trailer <input type="checkbox"/> None of the above <input type="checkbox"/> A light truck	Weather Conditions: <input type="checkbox"/> Clear <input type="checkbox"/> Rainy <input type="checkbox"/> Cloudy <input type="checkbox"/> Snowing <input type="checkbox"/> Drizzling <input type="checkbox"/> Storming <input type="checkbox"/> Foggy <input type="checkbox"/> Sunny	Road Conditions: <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Iced over <input type="checkbox"/> Dry with icy patches <input type="checkbox"/> Snowed over
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DESCRIBE MOMENT OF IMPACT

Body Position at impact: <input type="checkbox"/> Leaning forward <input type="checkbox"/> Slouched down in seat <input type="checkbox"/> Straight <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	Direction Body was thrown: <input type="checkbox"/> backward then forward <input type="checkbox"/> forward then backward <input type="checkbox"/> to the left <input type="checkbox"/> to the right <input type="checkbox"/> about the vehicle <input type="checkbox"/> outside the vehicle <input type="checkbox"/> under the vehicle	Head Position at impact: <input type="checkbox"/> Straight <input type="checkbox"/> Tilted forward <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	Direction head thrown: <input type="checkbox"/> backward then forward <input type="checkbox"/> forward then backward <input type="checkbox"/> side to side
Type of Passive Restraint: <input type="checkbox"/> Lap belt <input type="checkbox"/> Shoulder belt <input type="checkbox"/> Shoulder-lap belt	Did airbag deploy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Position of Headrests: <input type="checkbox"/> In the high position <input type="checkbox"/> In the low position <input type="checkbox"/> In the middle position <input type="checkbox"/> Not installed	Did you brace for impact? <input type="checkbox"/> Yes <input type="checkbox"/> No

Post-Injury

WHAT HAPPENED IMMEDIATELY AFTER THE ACCIDENT?

Initial reaction (mark all that apply) <input type="checkbox"/> Confused <input type="checkbox"/> Dazed <input type="checkbox"/> Distressed <input type="checkbox"/> Dizzy <input type="checkbox"/> Frightened <input type="checkbox"/> Light-headed <input type="checkbox"/> Nervous <input type="checkbox"/> Shaken <input type="checkbox"/> Upset <input type="checkbox"/> Weak	After the accident, in which body areas did you experience pain? (mark all that apply) <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Left shoulder</td> <td><input type="checkbox"/> Right shoulder</td> <td><input type="checkbox"/> Left arm</td> <td><input type="checkbox"/> Right arm</td> <td><input type="checkbox"/> Left elbow</td> <td><input type="checkbox"/> Right elbow</td> <td><input type="checkbox"/> Left forearm</td> <td><input type="checkbox"/> Right forearm</td> </tr> <tr> <td><input type="checkbox"/> Left wrist</td> <td><input type="checkbox"/> Right wrist</td> <td><input type="checkbox"/> Left hand</td> <td><input type="checkbox"/> Right hand</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Rib cage</td> <td><input type="checkbox"/> Upper back</td> <td><input type="checkbox"/> Mid back</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Lower back</td> </tr> <tr> <td><input type="checkbox"/> Left wrist</td> <td><input type="checkbox"/> Right wrist</td> <td><input type="checkbox"/> Left hand</td> <td><input type="checkbox"/> Right hand</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Rib cage</td> <td><input type="checkbox"/> Upper back</td> <td><input type="checkbox"/> Mid back</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Lower back</td> </tr> <tr> <td><input type="checkbox"/> Pelvis</td> <td><input type="checkbox"/> Left buttock</td> <td><input type="checkbox"/> Right buttock</td> <td><input type="checkbox"/> Left leg</td> <td><input type="checkbox"/> Right leg</td> <td><input type="checkbox"/> Left hip</td> <td><input type="checkbox"/> Right hip</td> <td><input type="checkbox"/> Left thigh</td> <td><input type="checkbox"/> Right thigh</td> <td><input type="checkbox"/> Left knee</td> </tr> <tr> <td><input type="checkbox"/> Right knee</td> <td><input type="checkbox"/> Left shin</td> <td><input type="checkbox"/> Right shin</td> <td><input type="checkbox"/> Left ankle</td> <td><input type="checkbox"/> Right ankle</td> <td><input type="checkbox"/> Left foot</td> <td><input type="checkbox"/> Right foot</td> <td></td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left elbow	<input type="checkbox"/> Right elbow	<input type="checkbox"/> Left forearm	<input type="checkbox"/> Right forearm	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Left hand	<input type="checkbox"/> Right hand	<input type="checkbox"/> Chest	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Upper back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Lower back	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Left hand	<input type="checkbox"/> Right hand	<input type="checkbox"/> Chest	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Upper back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Lower back	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Left buttock	<input type="checkbox"/> Right buttock	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Left hip	<input type="checkbox"/> Right hip	<input type="checkbox"/> Left thigh	<input type="checkbox"/> Right thigh	<input type="checkbox"/> Left knee	<input type="checkbox"/> Right knee	<input type="checkbox"/> Left shin	<input type="checkbox"/> Right shin	<input type="checkbox"/> Left ankle	<input type="checkbox"/> Right ankle	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot				Did you lose Consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Destination after injury (choose one) <input type="checkbox"/> Work <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Clinic <input type="checkbox"/> School <input type="checkbox"/> Doctor Any emergency care? <input type="checkbox"/> Bandages <input type="checkbox"/> Bracing <input type="checkbox"/> CPR <input type="checkbox"/> Neck Collar <input type="checkbox"/> Splinting
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left elbow	<input type="checkbox"/> Right elbow	<input type="checkbox"/> Left forearm	<input type="checkbox"/> Right forearm																																												
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Please indicate any lacerations (cuts) resulting from the accident (mark all that apply) <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Left shoulder</td> <td><input type="checkbox"/> Right shoulder</td> <td><input type="checkbox"/> Left arm</td> <td><input type="checkbox"/> Right arm</td> <td><input type="checkbox"/> Left elbow</td> <td><input type="checkbox"/> Right elbow</td> <td><input type="checkbox"/> Left forearm</td> <td><input type="checkbox"/> Right forearm</td> </tr> <tr> <td><input type="checkbox"/> Left wrist</td> <td><input type="checkbox"/> Right wrist</td> <td><input type="checkbox"/> Left hand</td> <td><input type="checkbox"/> Right hand</td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Rib cage</td> <td><input type="checkbox"/> Upper back</td> <td><input type="checkbox"/> Mid back</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Lower back</td> </tr> <tr> <td><input type="checkbox"/> Pelvis</td> <td><input type="checkbox"/> Left buttock</td> <td><input type="checkbox"/> Right buttock</td> <td><input type="checkbox"/> Left leg</td> <td><input type="checkbox"/> Right leg</td> <td><input type="checkbox"/> Left hip</td> <td><input type="checkbox"/> Right hip</td> <td><input type="checkbox"/> Left thigh</td> <td><input type="checkbox"/> Right thigh</td> <td><input type="checkbox"/> Left knee</td> </tr> <tr> <td><input type="checkbox"/> Right knee</td> <td><input type="checkbox"/> Left shin</td> <td><input type="checkbox"/> Right shin</td> <td><input type="checkbox"/> Left ankle</td> <td><input type="checkbox"/> Right ankle</td> <td><input type="checkbox"/> Left foot</td> <td><input type="checkbox"/> Right foot</td> <td></td> <td></td> <td></td> </tr> </table>				<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left elbow	<input type="checkbox"/> Right elbow	<input type="checkbox"/> Left forearm	<input type="checkbox"/> Right forearm	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Left hand	<input type="checkbox"/> Right hand	<input type="checkbox"/> Chest	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Upper back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Lower back	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Left buttock	<input type="checkbox"/> Right buttock	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Left hip	<input type="checkbox"/> Right hip	<input type="checkbox"/> Left thigh	<input type="checkbox"/> Right thigh	<input type="checkbox"/> Left knee	<input type="checkbox"/> Right knee	<input type="checkbox"/> Left shin	<input type="checkbox"/> Right shin	<input type="checkbox"/> Left ankle	<input type="checkbox"/> Right ankle	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot													
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TREATMENTS ADMINISTERED AFTER THE ACCIDENT

Were you admitted to a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Hospital/Clinic: _____ Examining Physician: _____ Date of Visit: _____ Date of Discharge: _____
Were any X-Rays taken? (mark all that apply) Y N (Please circle one) If yes, what body region? _____	
Were any CAT scans performed? (mark all that apply) Y N (Please circle one) If yes, what body region? _____	
Were any MRI scans performed? (mark all that apply) Y N (Please circle one) If yes, what body region? _____	
Were you given a diagnosis of this injury? _____	

Treatments Administered <input type="checkbox"/> Adjustments <input type="checkbox"/> Splint <input type="checkbox"/> Bandages <input type="checkbox"/> Support <input type="checkbox"/> Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Cast <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Collar <input type="checkbox"/> Oral medication <input type="checkbox"/> Hot Packs <input type="checkbox"/> Sutures <input type="checkbox"/> Ice Packs <input type="checkbox"/> Topical Antiseptic <input type="checkbox"/> Injection	Recommendations <input type="checkbox"/> No further care required <input type="checkbox"/> Refer to Plastic Surgeon <input type="checkbox"/> Refer to Chiropractor <input type="checkbox"/> Refer to General Practitioner <input type="checkbox"/> Refer to General Surgeon <input type="checkbox"/> Refer to Internist <input type="checkbox"/> Refer to Neurologist <input type="checkbox"/> Refer to Orthopedist	<input type="checkbox"/> Refer to Physical Therapist <input type="checkbox"/> See Physician if symptoms persist <input type="checkbox"/> Time off work <input type="checkbox"/> Undergo observation <input type="checkbox"/> Heat therapy <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Orthopedic shoes <input type="checkbox"/> Rest <input type="checkbox"/> Ice packs <input type="checkbox"/> Other: _____	Medications Prescribed <input type="checkbox"/> Antibiotic <input type="checkbox"/> Anti-Inflammatory <input type="checkbox"/> Anxiety medications <input type="checkbox"/> Herbs <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Pain Killers <input type="checkbox"/> Other: _____
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Treatment and Diagnostic History

Diagnostic Testing (X-ray, MRI, EMG, etc.)	Body Area	Date	Facility	Finding

Diagnostic tests that have been performed for the current chief complaint include:

Prior Physician: _____ **Date of 1st Visit:** ____/____/____
Physician's Diagnosis: _____ **Date of Last Visit:** ____/____/____

Treatment Recommended by Prior Physician (mark all that apply) <input type="checkbox"/> Adjustments <input type="checkbox"/> Immobilization <input type="checkbox"/> Analgesics <input type="checkbox"/> Nerve Blocks <input type="checkbox"/> Bed Rest <input type="checkbox"/> Massage <input type="checkbox"/> Anti-Biotics <input type="checkbox"/> Sedatives <input type="checkbox"/> Heat <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Anti-Inflammatories <input type="checkbox"/> Trigger Point Injections <input type="checkbox"/> Ice <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Surgery	Treatment Results (mark one) <input type="checkbox"/> Plan was not followed <input type="checkbox"/> Had some success <input type="checkbox"/> Aggravated the condition <input type="checkbox"/> Relieved the condition <input type="checkbox"/> Offered no relief or benefit
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Social History											
Marital Status? <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		# of Children? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> No children <input type="checkbox"/> 1 child <input type="checkbox"/> 2 children <input type="checkbox"/> 3 children </div> <div> <input type="checkbox"/> 4 children <input type="checkbox"/> 5 children <input type="checkbox"/> 6 children <input type="checkbox"/> 7 children </div> <div> <input type="checkbox"/> 8 children <input type="checkbox"/> 9 children <input type="checkbox"/> 10 children </div> </div>			How often do you exercise? <input type="checkbox"/> never <input type="checkbox"/> rarely <input type="checkbox"/> occasionally <input type="checkbox"/> regularly		Hand of Dominance? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Ambidextrous		Hours of Sleep per night? <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 5 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 7 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> 9 hours <input type="checkbox"/> 10 or more		
Participation in Sports Activities? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> very frequently <input type="checkbox"/> often <input type="checkbox"/> somewhat often <input type="checkbox"/> occasionally </div> <div> <input type="checkbox"/> infrequently <input type="checkbox"/> almost never <input type="checkbox"/> never </div> </div>				Involvement in Hobbies? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> very frequently <input type="checkbox"/> often <input type="checkbox"/> somewhat often <input type="checkbox"/> occasionally </div> <div> <input type="checkbox"/> infrequently <input type="checkbox"/> almost never <input type="checkbox"/> never </div> </div>			Have you traveled internationally? <input type="checkbox"/> never <input type="checkbox"/> recently <input type="checkbox"/> occasionally <input type="checkbox"/> in the past				
How often do you eat a well-balanced diet? <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> always <input type="checkbox"/> rarely <input type="checkbox"/> usually				Do you consider yourself overweight? <input type="checkbox"/> yes <input type="checkbox"/> no		How many pounds overweight? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> 5 <input type="checkbox"/> 15 <input type="checkbox"/> 25 <input type="checkbox"/> 35 <input type="checkbox"/> 45 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 40 <input type="checkbox"/> _____ </div> </div>					
Highest level of education achieved? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Did not graduate <input type="checkbox"/> earned a GED <input type="checkbox"/> graduated High School <input type="checkbox"/> Associates Degree </div> <div> <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Masters Degree <input type="checkbox"/> PhD or Doctorate </div> </div>				Years of Education after High School? <input type="checkbox"/> _____		Learning Disabilities? <input type="checkbox"/> yes <input type="checkbox"/> No <input type="checkbox"/> unknown					
Alcohol Consumption? <input type="checkbox"/> does not drink alcoholic beverages <input type="checkbox"/> drinks alcoholic beverages rarely <input type="checkbox"/> drinks alcoholic beverages occasionally <input type="checkbox"/> drinks alcoholic beverages frequently <input type="checkbox"/> drinks alcoholic beverages often <input type="checkbox"/> usually only drinks alcoholic beverages on the weekends				Recreational Drug Use? (optional) <input type="checkbox"/> never <input type="checkbox"/> occasionally <input type="checkbox"/> often <input type="checkbox"/> in the past		How often do you drink beverages with caffeine? <input type="checkbox"/> never <input type="checkbox"/> less than 1 caffeinated beverage per day <input type="checkbox"/> 1-2 caffeinated beverages per day <input type="checkbox"/> 2-3 caffeinated beverages per day <input type="checkbox"/> 3-4 caffeinated beverages per day <input type="checkbox"/> 4-5 caffeinated beverages per day <input type="checkbox"/> more than 5 caffeinated beverages per day					
Tobacco Use?											
Years of Tobacco Use? <input type="checkbox"/> _____		Cigarettes <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> does not smoke <input type="checkbox"/> < 1/4 pack per day <input type="checkbox"/> 1/4 pack per day <input type="checkbox"/> 1/2 pack per day </div> <div> <input type="checkbox"/> 1 pack per day <input type="checkbox"/> 2 packs per day <input type="checkbox"/> 3 packs or > per day <input type="checkbox"/> in the past </div> </div>				Chewing tobacco <input type="checkbox"/> never used <input type="checkbox"/> occasionally <input type="checkbox"/> often <input type="checkbox"/> in the past		Cigars <input type="checkbox"/> never used <input type="checkbox"/> occasionally <input type="checkbox"/> often <input type="checkbox"/> in the past			
Served in the Military? <input type="checkbox"/> yes <input type="checkbox"/> No		Serve during Wartime? <input type="checkbox"/> yes <input type="checkbox"/> no		Suffer trauma from War? <input type="checkbox"/> yes <input type="checkbox"/> no		Branch of Service? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Army <input type="checkbox"/> Navy </div> <div> <input type="checkbox"/> Air Force <input type="checkbox"/> Marines </div> </div>					
Health History											
Please select all choices that apply to you, either currently or in the past.											
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Allergies <input type="checkbox"/> Angina <input type="checkbox"/> Anorexia <input type="checkbox"/> Aortic Aneurysm <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Breast Soreness </div> <div style="width: 33%;"> <input type="checkbox"/> Bulemia <input type="checkbox"/> Cancer <input type="checkbox"/> Colitis <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetes <input type="checkbox"/> Dislocated Joints <input type="checkbox"/> Dizziness <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy </div> <div style="width: 33%;"> <input type="checkbox"/> Fainting <input type="checkbox"/> Hay Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Attacks <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Irregular Bowel Habits <input type="checkbox"/> Irregular Menstrual </div> <div style="width: 33%;"> <input type="checkbox"/> Irritable Colon <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lung Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Painful Urination </div> <div style="width: 33%;"> <input type="checkbox"/> PMS <input type="checkbox"/> Polio <input type="checkbox"/> Profuse Menstrual <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scoliosis <input type="checkbox"/> Sexually Transmitted Diseases </div> <div style="width: 33%;"> <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Spinal Disc Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcer <input type="checkbox"/> Vaginal Discharge </div> </div>											
Are you presently taking any medications? If so, please list. _____ _____ _____											
Have you had any surgeries? If so, please list. _____ _____ _____											

Family History									
	Mother	Father	Siblings	Cousins	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	<input type="checkbox"/> Relatives Still Living <input type="checkbox"/> Relatives In Good Health
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis or Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Blindness was caused by:
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cataracts
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Congenital absence of ability
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma
Deafness*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Trauma
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Deafness was caused by:
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Congenital absence of ability
Diabetes Mellitus Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Meniere's Disease
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Otic Cancer
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Trauma
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family history negative for:
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cancer
Sciatica/Chronic Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disorders
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke
Ulcers or GI Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Seizures
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Liver Dysfunction
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney Pathologies
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> All Of The Above

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of ***Wilmington Family Chiropractic's Notice of Privacy Practices for Protected Health Information.***

Patient Name Printed

Date

Patient Signature

Authorized Provider Rep.

Personal Representative Printed

Personal Rep. Relationship

- [] I have received and accepted the conditions of the Appointment Authorization and Marketing Authorization forms and agree to receive appointment reminders, occasional newsletters, birthday cards, referral thank you cards, and practice and service updates.

Signature

- [] Exceptions:

Signature

CONSENT TO TREAT

I understand that all records established by this office are the sole property of Dr. Jensen. Copies, however, will be made upon 72 hours written to the doctor, and I understand and agree to pay all costs involved in their reproduction.

I hereby give Wilmington Family Chiropractic and Dr. Jensen CONSENT TO TREAT me and/or my minor child, and I understand that Wilmington Family Chiropractic requires personal payment for all services rendered today.

I, the undersigned, hereby authorize Dr. Jensen (and whom he may designate his assistants) to administer any examination and/or treatment as is necessary and to perform appropriate diagnostic and therapeutic procedures as are considered necessary on the basis of findings during the course of said examination and/or treatment. I also authorize the release of any information or records from this office to other past, present or future health care professionals, facilities, attorneys or agencies for the purpose of continuity of my health care and for the purpose of collection for services rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Wilmington Family Chiropractic 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 Wilmington Family Chiropractic and Dr. Jensen will be credited to my account on receipt. I also give Wilmington Family Chiropractic and Dr. Jensen limited power of attorney to endorse checks received from my insurance company relating only for my treatment, to be credited to my account. However, I clearly understand and agree that all services rendered to me and/or my minor child are charged directly to me and that I am personally responsible for payment, regardless of my insurance coverage. I also understand that if I suspend or terminate my care and treatment and/or if in the event that my insurance benefits are terminated or exhausted, any fees for professional services rendered to me and/or my minor child will be immediately due and payable.

I also certify that no guarantee has been made as to the results that may be obtained from any treatment given.

By signing below, I affirm that I have read the above and that it has been clearly explained to me as well by Wilmington Family Chiropractic.

Patient (or Guardian) Signature

Date

FEMALE PATIENT X-RAY PREGNANCY VERIFICATION

I, _____, a patient of Wilmington Family Chiropractic, certify that to the best of my knowledge that I am not pregnant. By my signature below, I authorize Wilmington Family Chiropractic and Dr. Jensen to take all appropriate diagnostic x-rays. If there is even a remote chance of pregnancy, I will notify Dr. Jensen immediately.

Signed: _____

Date: _____

Doctor's Signature: _____

Date: _____

ASSIGNMENT, LIEN AND AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION

Patient Name: _____

For good and valuable consideration received, I, _____, being the undersigned, authorize and direct you, _____ my insurance carrier and _____, my attorney, to pay directly to WILMINGTON FAMILY CHIROPRACTIC any sums as may be due and owing this office for services rendered me, both by reason of accident, or illness and/or by reason of any other bills, medical payments, no-fault benefits, health and/or accident benefits, workers' compensation benefits, or any other insurance benefits or reimbursement for which you may be obligated to reimburse me, or from any settlement, judgement or verdict on my behalf as may be necessary to adequately protect WILMINGTON FAMILY CHIROPRACTIC and Dr. Stephen Jensen who provided these services.

I hereby give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgement or verdict, which may be owed me as a result of the injuries or illness for which I have been treated by said office. This contract is to act as an assignment of my rights and benefits to the extent of the office's charges for services provided herein.

In further consideration of the treatment rendered herein, I do hereby authorize WILMINGTON FAMILY CHIROPRACTIC to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I, the undersigned, further hereby authorize and direct my attorney, _____, when settlement or judgment is reached, to pay in full the chiropractic bills rendered for all treatment and services as a result of the injuries or illness for which I have been treated by said office and any other amounts which I may owe said office at that time.

In further consideration of the treatment rendered herein, I do hereby authorize WILMINGTON FAMILY CHIROPRACTIC to furnish you, the above-indicated party, a full report of my examination, diagnosis, treatment, prognosis, chiropractic bills and any other relevant information pertaining to my treatment.

I understand that by signing this document, I am authorizing release of reports and information to the above-indicated party, which could include the responsible party's insurance company.

Furthermore, I authorize WILMINGTON FAMILY CHIROPRACTIC to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and medical authorization.

In the event that the insurance company is obligated to make payments to me for charges made by this office for services rendered and refuses to make such payments, I hereby assign and transfer to this office any and all cause of action, claims, whether in law or equity, that I might have or that I might exist in my favor against such company, and authorize this office to compromise, settle or otherwise resolve any claim or cause of action in its sole discretion herein as it relates to amounts owed the doctor.

I understand that I am directly and fully responsible to said office for all medical bills submitted by them for services rendered to me and this agreement is made solely for said office's additional protection while awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fees.

This agreement is irrevocable and is binding upon the heirs, executors and legal representatives of the undersigned. Therefore, I the undersigned has hereunto set his/her hand this _____ day of _____, 2010.

Patient

ATTORNEY ACKNOWLEDGEMENT OF ASSIGNMENT, LIEN AND AUTHORIZATION AND RELEASE OF MEDICAL RECORDS AND INFORMATION.

I, _____, attorney for the above-named patient, hereby acknowledge receipt of the above assignment and lien and agree to protect WILMINGTON FAMILY CHIROPRACTIC and Dr. Stephen A. Jensen pursuant to the above-indicated terms.

Date: _____

Attorney: _____

NUTRITION SURVEY

Wilmington Family Chiropractic

Name

Date

1) Are you presently taking any type of nutritional supplements (such as vitamins, minerals, herbs, amino acids, fish oils, etc)?

_____ Yes _____ No

a. Name the supplements that you are presently taking:

b. Who recommended you take these supplements?

_____	Family Member or Friend	_____	Advertisement
_____	Health Professional	_____	Other

c. Where did you purchase those supplements?

_____	Mail-order	_____	Pharmacy	_____	Other
_____	Nutrition or Vitamin Shop	_____	Health Care Provider		

2) If your doctor offered an advanced, high quality line of supplements, would you consider purchasing them? _____ Yes _____ No

3) If your doctor offered a simple, painless genetic test to determine, based on your DNA, which vitamins are most important for your body, would you consider having it? _____ Yes _____ No

4) If this office offered a comprehensive weight management program, would you consider it? _____ Yes _____ No

5) If this practice offered a nutrition education program to improve your dietary habits, would you be interested in participating if it was?

by private appointment with one of our staff? _____ Yes _____ No

by a class held exclusively for our patients? _____ Yes _____ No

We take your health seriously. If you have answered "Yes" to any of the above questions and would like our R.N. Nutritional Advisor to provide a complimentary consultation, please provide your contact information below:

Phone: _____

Best time to be reached: _____

Email: _____