Step 1:

Welcome! We are excited to serve your health care needs in an effective and efficient manner. Please circle the times that would work best for your follow up visits. Please select all that may apply for three days.

Monday:	Early Morning	Late Morning
	Early Afternoon	Late Afternoon
Tuesday:	Early Afternoon	Late Afternoon
Wednesday:	Early Morning	Late Morning
	Early Afternoon	Late Afternoon
Thursday:	Early Morning	Late Morning
	Early Afternoon	Late Afternoon
Friday:	Early Morning	Late Morning

Office Hours are: M, W, TH- 9:00 am- 12:00 and 2:30 pm- 6:00pm

Tuesday- 2:30pm- 6:00pm Friday- 9:00 am – 1:00 pm

Step 2:

When it comes to your health, we believe that medical doctors and chiropractors should work together for **YOUR** benefit.

Dr. Tierney and I agree! I give you permission to inform my personal medical doctor of my condition, treatment, and expected/actual response to care at this office.

Sign: _____ Date:_____

Please print your name: _____

Your Medical Doctor _____

Doctor's Address_____

Doctor's Phone_____

CONFIDENTIAL PATIENT INFORMATION

Date_____

Home Phone (_____) _____

Name _____Work Phone (_____) _____

Address_____ Cell Phone(_____) _____

City_____ Zip Code_____ Email_____

Age_____ DOB _____ M F Marital M S W D How many Children? _____

Occupation _____ Employer _____

Address of work _____Office phone _____

Name of Spouse(or parent-if minor) _____Work phone _____

Employer_____ Address_____

Emergency Contact_____ _Address_____ Phone_____

Whom may we thank for referring you? _____

Purpose of this appointment/ current problem_____

Other doctors seen for this condition_____

Is the condition due to injury or sickness arising out of employment or auto accident?_____

Date symptoms appeared or accident happened_____ Days lost from work ( )Yes ( ) No

Do you suffer from:

1. Dizziness_____ 5. Neck Pain _____ 9. Shoulder/Arm Pain _____ 13. Nervousness_____

2. Back pain _____6. Arthritis _____ 10. Hip/Leg pain _____14. Sinus trouble _____

3. Heart trouble _____7. Headaches _____ 11. Urinary Problems _____ 15. M/F troubles _____

4. Diabetes _____8. Numbness_____12. Digestive Disorders _____16. Cancer _____

Do you smoke? ( ) Yes ( ) No _____ Packs a day Do you have a pacemaker? ( )Yes ( ) No

Have you been treated for any health condition by a physician in the past year? ( ) Yes ( ) No

Describe _____

Date of last physical examination _____ List surgeries _____

Serious Illnesses _____ Medications _____

What vitamins are you taking _____

If female, are you taking birth control pills? ( ) Yes ( ) No Pregnant ( ) Yes ( ) No

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION: By signing this form, you are granting consent to Tierney Chiropractic to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Policies provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you read it in full.

Our notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

_____

Patient Signature (or guardian signature authorizing care)

Insurance Company _____

Insured _____

Assignment and Instruction for Direct Payment to Doctor

Private and Group Accident and Health Insurance

Patient Name _____

Employer _____

Claim/ Group _____

ID # _____

I hereby instruct and direct the _____ Insurance Company to pay by check, make out to and mailed directly to:

Mark S. Tierney, D.C.

dba Tierney Chiropractic

301 Main Street

Reading, MA 01867

If my current policy prohibits direct payment to my doctor, then I hereby instruct and direct you to make the check payable to me and mail it to:

Mark S. Tierney, D.C.

dba Tierney Chiropractic

301 Main Street

Reading, MA 01867

For professional or medical expense benefits allowable and otherwise payable to me unless my current insurance policy as payment toward the total charges for processional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS, TITLES INTEREST AND BENEFITS TO THIS OFFICE UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, and balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Dated, this _____ day of _____, 20_____

Signature of Policy holder and/or claimant _____

Signature of Witness _____

Symptoms:

1. What is your major symptom ? _____
2. When was the first time you noticed this problem? _____
    a. How did it occur? _____
    b. Has it become worse recently? _____ If yes, when and how? _____
3. How frequent is the condition? _____
    a. How long does it last?_____
4. Have you ever had the same or similar condition? ( ) Yes ( ) No
   If yes, when and describe:_____
5. Are there any conditions or symptoms you have that may be related to your major symptoms? _____
6. If pain is involved, is it--- sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting? (other) _____
7. Does doing anything provide relief? _____
8. What makes the problem worse? _____
9. List all accidents, surgeries, or broken bones: _____

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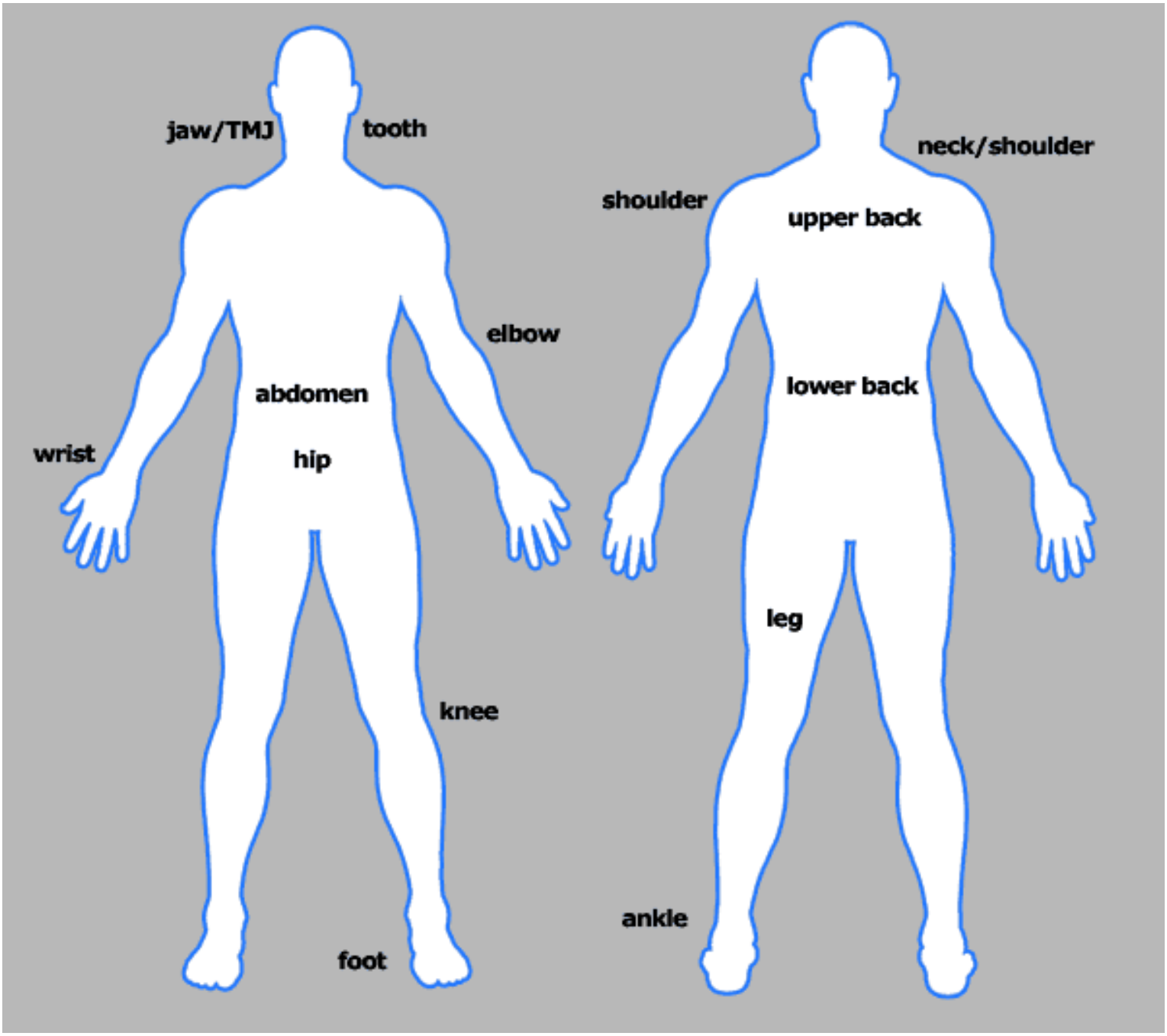
10. Rate the severity of your condition using the chart below:_____/10
11. Please mark your symptom areas


jaw/TMJ
tooth
elbow
abdomen
wrist
hip
knee
foot
neck/shoulder
shoulder
upper back
lower back
leg
ankle