Welcome,

We would like to take this opportunity to welcome you to Newport Chiropractic Center and to thank you for choosing our practice to participate in your healthcare. We look forward to providing you with personalized, comprehensive chiropractic care focusing on acute pain relief, wellness, and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our office staff work closely in a "team approach" to support your care.

Our office is open Monday 7am-6pm, Tuesday 8am-12pm, Wednesday 9am-6pm, Thursday 12pm-5pm, and Friday 7am-12pm. Every effort is made to see our patients during our varied hours. Please note that our schedulers do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality care.

As your chiropractic care provider, we work collaboratively with specialists to coordinate all aspects of our patient care including X-Rays, MRI's and specialty consultation care as needed.

Before your visit, please notify your health insurance company if your using your insurance to cover the charges and see what your insurance covers for chiropractic care. We also request that you bring a copy of your prior X-Rays, MRI's, CT scans and or radiology reports you have available.

Please fill out the enclosed forms and bring them with you to your appointment. During your initial visit we will be reviewing your health status and these forms contain information necessary to complete this prosses. Please bring your health insurance identification card as well as a photo ID. Please bring a complete list of all your medications. We will take your temperature and ask that you wear a mask due to covid restrictions.

Once again, we would like to thank you for choosing us and we look forward to working with you.

Sincerely, Dr. Saulter and Staff

Newport Chiropractic
Michael S. Saulter, D.C.
PO Box 367
Newport, ME 04953
Ph: (207)368-4318 Fax: 368-5224

Disclosure & Consent to Chiropractic Adjustments and Care

To the Patient: Please read completely prior to meeting with Dr. Saulter.

You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Dr. Saulter or those working at the clinic or office who now or in the future treat me while employed by, working for or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but no limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be signed by the patient/legal guardian

Patient's Name: ______________________ DOB: __________ Gender: M F ID# __________

X____ Date:____________

Patient's or Guardian's Signature.

Legal Guardian's Name (Print):______________________ Relationship:____________

OFFICE USE ONLY: To be initialed by the Doctor.

X____ Date:____________

Michael S. Saulter, D.C. (MSS)

Newport Chiropractic
Michael S. Saulter, D.C.
PO Box 367
Newport, ME 04953
(207) 368-4318 Fax: 368-5224

AUTHORIZATION AND ASSIGNMENT TO PAY CLAIMS DIRECTLY TO DOCTOR

To: (Attorney, Insurer, Employer, Other): ______________________
In consideration of the undertaking, by Michael S. Saulter D.C. (Newport Chiropractic)

I, ☐ Do ☐ DO NOT understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to that point, will be immediately due and payable.

A. In consideration of the chiropractic services rendered and to be rendered by Michael S. Saulter D.C. (Newport Chiropractic)., I authorize the direct payment of benefits to Newport Chiropractic., in the amount of any sum I now or hereafter owe by my attorney or out of the proceeds from any settlement of any liability case or by any insurance company obligated to make payment to me or Newport Chiropractic based in whole or in part, on the charges accrued for said services.
B. If a liability claim exists and my attorney or insurance carrier refuses assignment, I acknowledge my personal financial responsibility for payment in full of my outstanding balance.
C. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Michael S. Saulter, D.C. (Newport Chiropractic) has been paid in full.

PATIENT ACKNOWLEDGEMENT OF HIPPA NOTICE OF PRIVACY ACT

I, ☐ DO ☐ DO NOT acknowledge the receipt (at my request) or opportunity to review the

Notice of Privacy Practices Act (HIPPA)

For (**Newport Chiropractic.**), regarding my personal health care information. I am or have been informed and clearly understand the manner in which my health information shall be maintained, utilized and disclosed by the clinic and the respective rights contained within. I also understand that the Notice of Privacy Act that is available upon my request is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting or making a written request to:

Lisa Robinson – compliance Officer

My signature herein below constitutes full acknowledgement that I have been furnished the opportunity to review or obtain a copy of the Notice of Privacy Practices for: Michael S. Saulter, D.C. (**Newport Chiropractic**).

I have reviewed the medical information provided and I believe it to be true and accurate to the best of my knowledge.

Patient's Name:______________________ DOB:______________ Gender: M F ID#.______

X____ Date: ______________

Newport Chiropractic Center
Michael Saulter, DC PO Box 367 Newport, ME 04953-0367 PH (207) 368-4318 Fax (207) 368-5224

NEW PATIENT - History of Chief Complaint

Patient Name: ______________________ DOB: ______________ Gender:

What is your PRIMARY complaint/symptom? (Location and Description): ______________________

____

How did the symptom(s) start? (Please circle): Lifting Falling Work Accident Gradual Other: ______

When did your symptom(s) begin? (Most recent episode): ______________ days/weeks/month/yrs. ago

Have you had this condition in this past? No Yes If Yes: 1-2 3-4 5+ times before or a reoccurrence

How often do you experience these symptoms? (What percentage of the day are you aware of the symptoms?)

Occasionally (0-25%) Intermittently (26-50%) Frequently (51-75%) Constantly (76-100%)

Describe the quality and character of your symptom(s). (Please circle all that apply):

Sharp Dull Aching Burning Throbbing Numbness/Tingling Stabbing Pounding Shooting Other: ______

Rate the severity of your symptom(s)/pain level 0 to 10: (0 being no pain and 10 being excruciating pain)

Pain level: Right now: ______ On average: ______ At the Worst: ______ At the Best:

What aggravates your condition? (Please circle all that apply): Bending Lifting Sitting Working

Sleeping Driving Walking Coughing Sneezing Stress Housework Exercise Morning Evening

What makes your condition better? (Please circle all that apply): Ice Heat Stretching Movement

Rest Prescription Medication Over the Counter Medication Other: ______________________

Do you have radiating symptoms? No Yes If yes where to: ______________________

How is your condition changing? Is it getting better? Better Worse Not changing

Have you seen any other provider(s) or had any other treatment for your condition? No Yes

If yes: List provider, treatment, and result: ______________________

Do you have any secondary or associated symptom(s): No Yes

If yes, list other symptom(s): ______________________

What do you do for work? ______________________

What activities outside of work or recreational activities do you do: ______________________

How is the quality of your sleep? Good OK Poor On average I sleep ________ hrs./night

What position do you sleep in? Back Side (Left Right or both) Stomach

How many pillows do you sleep with? One Two Several

How old is your bed? ____Years old Type of bed? ________ Is it: Firm Soft Comfortable Uncomfortable

What are your goals of treatment here? ______________________

Patient signature: ______________________ Date: ____________

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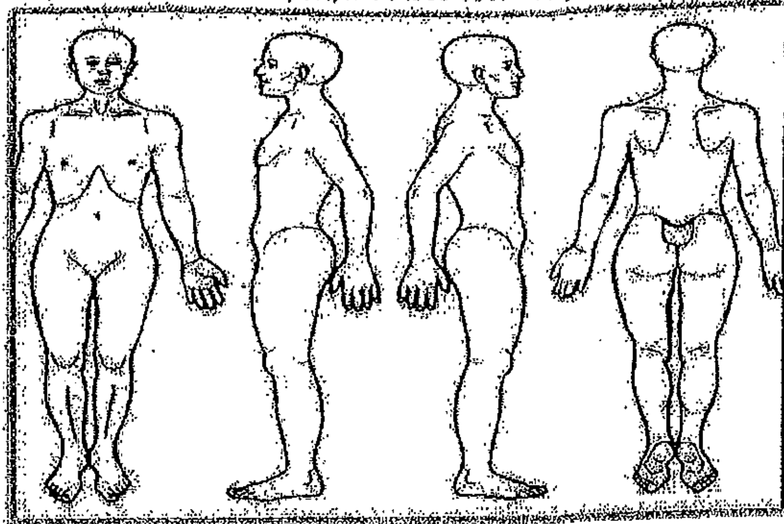

Past History:

Do you have: Hypertension [ ] Diabetes [ ] High Cholesterol [ ]

List of Medications you are currently taking: ___ None ______________________________

______________________________ or see list [ ]

Allergies:__ None ______________________________ or see list [ ]

Surgeries: __ None ______________________________ or see list [ ]

Hospitalizations:__ None ______________________________

Major Illnesses:__ None ______________________________

Pertinent family history (Cancer, cardiovascular disease, diabetes etc)

Relationship	History	Deceased?	Cause of Death

Occupation: ____________________ or circle: Student Unemployed Retired
How long have you been at your current job? ____years
Marital Status: Single Married Divorced Widowed
With whom do you currently live? Alone Spouse Spouse/Children Significant Other Other
Smoking Status: Current Former Never
Alcohol Intake: None Casual Moderate Heavy
Caffeine Intake: None <3/day 3 to 6 a day >6 a day
Recreational Drugs: None Recreational User Addict
Exercise Frequency: Never Daily (3-7x/week) Weekly Type of Exercise?____________________

Who is your Primary Care Physician?____________________ Office:____________________

Female patients only: To the best of your knowledge, are you pregnant? Yes or No

Who may we thank for referring you to our office? ____________________

Patient Signature:______________________________ Date:____________________

Newport Chiropractic Center - Michael S. Saulter, D.C.
PO Box 367Newport, ME 04953-0367

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: ______________________________ DOB: __________ Todays Date: __________

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is severe.
5 The pain is severe and does not vary much.

SECTION 2 - Personal Care

0 I do not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increases the pain but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
44 Because of the pain I am unable to do some washing and dressing without help.
5 Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor.
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights at the most.

SECTION 4 - Walking

0 I have no pain on walking.
1 I have some pain on walking but it does not increase with distance.
2 I cannot walk more than one mile without increasing pain.
3 I cannot walk more than 1/2 mile without increasing pain.
4 I cannot walk more than 1/4 mile without increasing pain.
5 I cannot walk at all without increasing pain

SECTION 5 - Sitting

0 I can sit in any chair as long as I like.
1 I can sit only in my favorite chair as long as I like.
2 Pain prevents me from sitting more than one hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases pain straight away.

SECTION 6 - Standing

0 I can stand as long as I want without pain.
1 I have some pain on standing but it does not increase with time.
2 I cannot stand for longer than one hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

0 I get no pain in bed.
1 I get pain in bed but it does not prevent me from sleeping well.
2 Because of pain my normal night's sleep is reduced by less than 1/4.
3 Because of pain my normal night's sleep is reduced by less than 1/2.
4 Because of pain, my normal night's sleep is reduced by less than 3/4.
5 Pain prevents me from sleeping at all.

SECTION 8 - Social Life

0 My social life is normal and gives me no pain.
1 My social life is normal but increases the degree of my pain.
2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3 Pain has restricted my social life, and I do not go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

SECTION 9 - Travel

0 I get no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
2 I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling, which compels me to seek alternative forms of travel.
4 Pain restricts all forms of travel.
5 Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

0 My pain is rapidly getting better.
1 My pain fluctuates but overall is definitely getting better.
2 My pain seems to be getting better but improvement is slow at present.
3 My pain is neither getting better nor worse.
4 My pain is gradually worsening.
5 My pain is rapidly worsening.

SIGNATURE: ______________________

Disability Score: _____% /100

Newport Chiropractic Center
PO Box 367
Nwport, Maine 04953-0367
Ph 207- 368-4318

Modified Oswestry Neck Disability Questionnaire

Patient Name: ______________________ Date of Birth: ___________ Today's Date: __________

This questionnaire has been designed to give us information as to how your neck problem is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize that you may consider that two or more statements in any one section apply but please just **choose the one that most clearly describes your problem.**

Section 1: Pain Intensity

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain is moderate at the moment
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing, etc.)

0 I can look after myself normally without causing extra pain
1 I can look after myself but it causes extra pain
2 It is painful to look after myself if I am slow and careful
3 I need some help but can manage most of my personal care
4 I need help every day in most aspects of self-care
5 I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it gives me extra pain
2 Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently placed
3 Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
4 I can only lift very light weights
5 I cannot lift or carry anything

Section 4: Reading

0 I can read as much as I want to with no neck pain
1 I can read as much as I want to with only a slight increase in neck pain
2 I can read as much as I want to with a moderate increase in neck pain
3 Pain prevents me from reading as much as I want to
4 I can hardly read at all because of neck pain
5 I cannot read at all because of my neck pain

Section 5: Headaches

0 I have no headaches at all
1 I have mild headaches that come infrequently
2 I have moderate but infrequent headaches
3 I have moderate and frequent headaches
4 I have severe and frequent headaches
5 I have a headache almost all the time

Section 6: Concentration

0 I can concentrate fully and with no difficulty
1 I can concentrate fully but with slight difficulty
2 I can concentrate fully but only for short periods of time
3 I have a fair degree of difficulty concentrating
4 I have a lot of difficulty concentrating
5 I cannot concentrate at all.

Section 7: Sleeping

0 My sleep is never disturbed by pain
1 My sleep is occasionally disturbed by pain
2 Because of pain I have less than 6 hours of sleep
3 Because of pain I have less than 4 hours of sleep
4 Because of pain I have less than 2 hours of sleep
5 I can't sleep at all because of the pain

Section 8: Work

0 I can do as much work as I want to
1 I can only do my usual work but no more
2 I can do most of my usual work but with difficulty
3 I cannot do my usual work
4 I can hardly work
5 I cannot work at all

Section 9: Social life

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases my pain
2 Pain limits only my more energetic interests, e.g. sport
3 Pain has restricted my social life and I do not go out as often
4 Pain has restricted my social life to my home
5 I have no social life because of pain

Section 10: Traveling

0 I can travel anywhere without pain
1 I can travel anywhere but it gives me extra pain
2 Pain is bad but I manage trips longer than 2 hours
3 Pain restricts me to trips of less than one hour
4 Pain restricts me to trips of less than 30 minutes
5 Pain prevents me from traveling except to receive treatment

Score: ____%

Patient Signature: ______________________________