Phone: (603) 203-3185 · **Fax:** (603) 626-6950
1650 Elm St. Suite 301 Manchester, NH 03101

Dr. Steve Baroody

Patient Information Sheet

Date: _____ Name: _____
Address: _____
City: _____ State/Zip: _____
Cell Phone: (_____) _____ - _____ Social Security Number: _____
In case of emergency, contact: _____ Phone: (_____) _____-_____
Birthdate: ____/____/_____ Male: _____ Female: _____
MM DD YY
Height: _____ Weight: _____ Shoe Size: _____
Please list your hobbies, sports, and other interests:

_____
_____
How did you hear about us? _____

Work Information

Position: _____
Employer: _____ Supervisor: _____
Employer Address: _____
Phone at work: (_____) _____ - _____ ext _____

Physician Information

Name of Primary Physician: _____
Address: _____
Phone: (_____) _____-_____

Visit Information

Referral by: _____
What is the reason for your visit today? _____
_____

Insurance Information

Insurance Company & phone number:_____
Name of Insured: _____ Insured date of birth: _____
Policy Number: _____ Relationship to Patient: _____

Is your condition due to an accident _____ or illness _____?
If an accident, did it occur at work? _____ Date of accident: _____

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Patient Last Name:	First Name:	MI:	Daytime Phone:
Date:	SS Number:		Evening Phone:

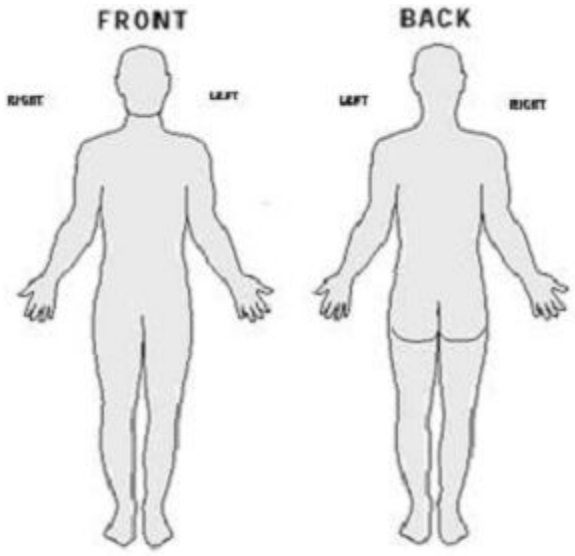
Please list the reasons or condition for your visit in the order of importance, along with the date you first noticed, most important at the top.	Pain &/or Symptoms Circle the number that best reflects your condition: (0= no effect 10= severe)	Pain &/or Symptoms Circle how much of the time your experience your condition:
A.	0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
B.	0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
C.	0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
D.	0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%

For each condition listed above, please indicate how it happened:

A. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
B. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
C. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
D. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know

For each condition listed above, please indicate if it is better or worse with any of the following:

	Heat	Cold	Rest	Activity	Other:_____
A.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
B.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
C.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
D.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse



Please indicate if your condition limits any of the following activities:

Activity	Normal	Somewhat Limited	Severely Limited
Lifting			
Bending			
Standing			
Walking			
Sitting			
Climbing stairs			
Running			
Resting			
Intercourse			
Comp. work/typing			
Normal work			
Household activ.			
Recreational activ.			
Other			

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Please mark the areas of your discomfort on the figures at right, using the symbol which best describes the feeling: +++ sharp, stabbing; 000 pins & needles; VVV dull, aching; /// numbness	Comments:

Last Name: First Name:	Date:

During what time of day do you feel worst? _____
Do you sleep well? Yes ❑ No ❑
What are your normal sleeping hours? _____
Are you currently under the care of a medical doctor or other health care provider for any condition?
Yes ❑ No ❑ Condition: _____
Name of doctor/provider: _____ Phone: _____
Have you ever had an overnight stay in a hospital or surgical procedure of any kind? Yes ❑ No ❑
Date and Description: _____
Date and Description: _____
Do you exercise? Yes ❑ No ❑
Description: _____ Frequency/Minutes per session: _____
Description: _____ Frequency/Minutes per session: _____

Please read through the following list and check any which may apply to you	·Types of Pain· __Severe pain interrupts sleep __Constant pain not improved by changing positions or lying down
·Pain in Body· __Neck pain with difficulty swallowing __Extreme neck stiffness with pain or electrical shocks in arms or legs when moving neck __Leg pain that worsens with exercise but is relieved by resting __Loss of feeling in inner thighs __Back pain with urinary problems	·Prior diagnosed condition/Medical History· __Congenital bone or joint disorder __Rheumatoid arthritis __Severe degenerative arthritis __History of compression fracture __History of heart attack __History of stroke or aneurysm __Past history of cancer or currently diagnosed with cancer
·Current Conditions· __Unable to balance properly __Recent unexplained weight loss __Recent progressive muscle weakness or shaking __Blurred or double vision, dizziness, nausea or faintness when neck is in certain position __Recent major accident such as a fall from a height, whiplash, or a blow to the head __Memory loss after injury	__Diabetes with cold, burning, or numb feet __Gout __Lupus __Ankylosing spondylitis __Immune suppression due to chemotherapy, organ transplant, etc. __3 or more months use of steroid medications or intravenous drugs (past or recent)

Please read through the following list and check any which apply to you.
__Autoimmune Disorders __Cancer __Heart Disease __Mental Illness
__Arthritis __Diabetes __Kidney Disease __Seizure Disorder

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Based on all the things you do to cope, or deal with, your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. Remember, you can circle only one number along the scale.

No control — Some — Complete control

0 1 2 3 4 5 6 7 8 9 10

Based on all the things you do to cope, or deal with, your pain, on an average day, how much are you able to decrease it?

No control — Some — Complete control

0 1 2 3 4 5 6 7 8 9 10

How confident are you in your ability to overcome your problem?

Total confidence — No confidence

0 1 2 3 4 5 6 7 8 9 10

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Notice of Privacy Practices

The Health Insurance Portability and Accountability Act concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice. A partial list of your rights includes but is not limited to allowing (or prohibiting) health care providers from revealing information with your permission, as necessary, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing for services rendered. Information includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birth date, etc. We will coordinate with all parties necessary for prompt, accurate and effective treatment and proper billing. We will gladly explain all aspects of your care to you or assigned persons as you wish.

Name: (printed) _____Signature: _____ Date:_____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.
Today's date: _____ *Signature of patient:* _____

If patient required assistance to complete information forms, please sign below and state your relationship to the patient.
Today's date: _____ *Signature:* _____ *Relationship to patient:* _____

Cancellation Policy

In consideration to your fellow patients, we ask that you give us 24 hours notice of all cancellations and rescheduling. In the event that you do not, we reserve the right to charge you $40 for the missed appointment. Please note, this fee is *not covered* by your insurance.

Signature: _____ Date: _____

Lien

In consideration for services rendered by Dr. Steven Baroody, d/b/a NH Spine and Sport, PLLC, I,_____, agree that I am responsible for payments of all co-payments, deductibles, coinsurance and charges for services not covered by my insurance policy or from another payment source (for example: workers compensation, legal settlement, medicare, etc.). I agree to present an insurance card, if applicable, so that Dr. Steven Baroody, d/b/a NH Spine & Sport, PLLC, can make every effort to notify my insurance company that I am a patient of Dr. Baroody, in order to obtain authorization, if necessary.

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I make this statement with the full knowledge and understanding that I am responsible for payments and any debt incurred may result in legal proceedings against me by Dr. Steven Baroody, d/b/a NH Spine & Sport, PLLC. I accept responsibility for this and hereby authorize this establishment to perform any and all necessary services at this time.

Signature: _____ Date: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date: