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

Dr. Steve Baroody, D.C.

PATIENT DATA SHEET

PERSONAL INFORMATION DATE: ____________________________

PATIENT NAME: ____
First Middle Initial Last

ADDRESS: ____

CITY: ____ STATE: ______________________ ZIP CODE: _________________

HOME PHONE: (_____)________________________ WORK / CELL PHONE: (_____)____________________________

DATE OF BIRTH: _______________ GENDER: _____ MARITAL STATUS: S M D W EMPLOYER: ________________________

OCCUPATION: ____ REFERRED BY: ____

EMERGENCY CONTACT NAME: ____________________________ RELATIONSHIP: ____

PHONE #: ____ EMAIL ADDRESS: ____

PRIMARY CARE PHYSICIAN: ______________________________ PHONE NUMBER: ____

RESPONSIBLE PARTY INFORMATION / NAME OF INSURED

NAME: ____
First Middle Initial Last

ADDRESS: ____

CITY: ____ STATE: ______________________ ZIP CODE: _________________

HOME PHONE: (_____)________________________ ALTERNATE PHONE: (_____)____________________________

SOC SEC #: ___________________________________ DATE OF BIRTH: ___________________ GENDER: _____

EMPLOYER: ___________________________________ OCCUPATION: ____

PATIENT HISTORY / REVIEW OF SYSTEMS

Name: ____________________________________ Date: ________________________________

Please tell us if YOU or a member of YOUR IMMEDIATE FAMILY have had any of the following.

	Individual		**Family Member**	
Back pain / Leg pain	Yes	No	Yes	No
Neck Pain / Arm Pain	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Neurological Disease / Headaches / Seizures	Yes	No	Yes	No
Heart / Circulatory Problems	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Stomach or Bowel Problems	Yes	No	Yes	No
Broken Bones	Yes	No	Yes	No
Skin Disease	Yes	No	Yes	No
Prostate Disease / Hormone Therapy	Yes	No	Yes	No
Depression, Anxiety, etc.	Yes	No	Yes	No
Painful or Irregular Menstrual Cycles	Yes	No	Yes	No

Please tell us about your medical history:

Exercise on a regular basis	Yes	No	Yes	No
Motor Vehicle Accident or Other Injuries	Yes	No	Yes	No
Alcohol / Nicotine	Yes	No	Yes	No
Allergies/Upper respiratory infection/flu/cough	Yes	No	Yes	No
Surgeries	Yes	No	Yes	No
Chiropractic Treatment Before	Yes	No	Yes	No
Unintended weight gain / loss	Yes	No	Yes	No
Recent international travel	Yes	No	Yes	No

Please list your medications: ____

Please explain any "Yes" answers above:

____

____

____

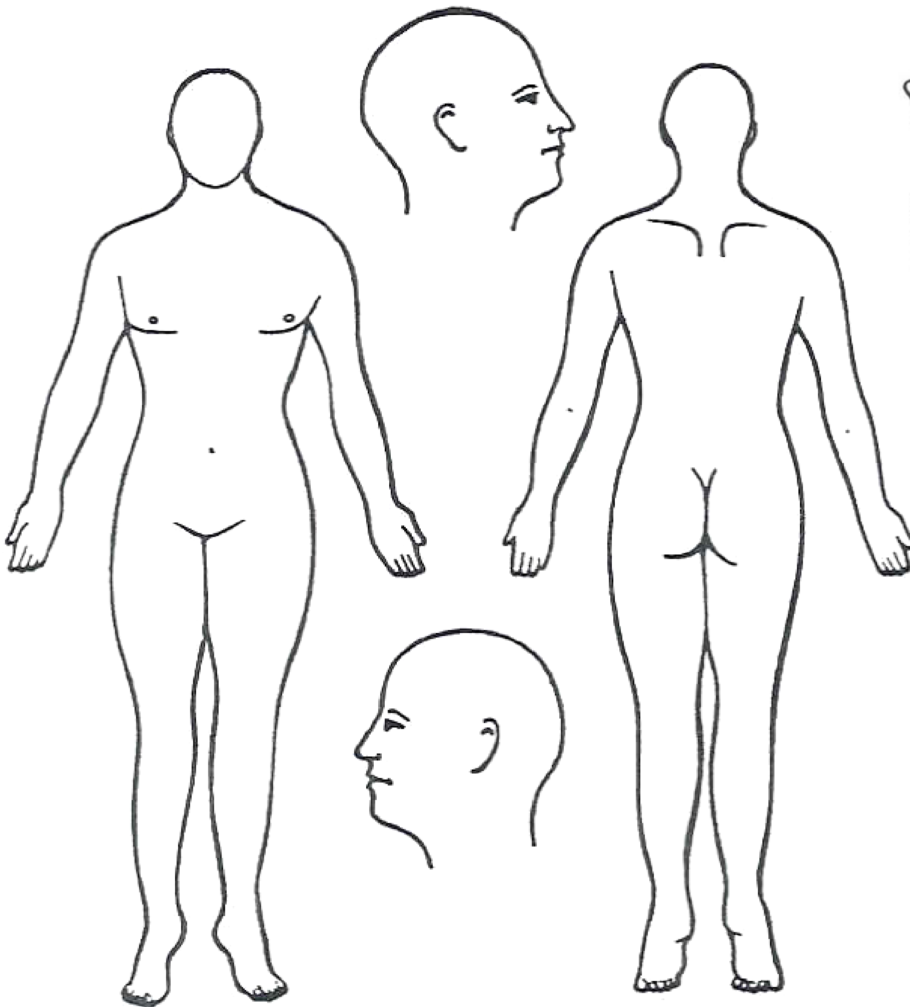
Pain Drawing

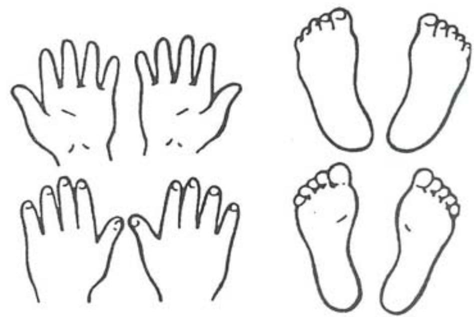
Name: ______________________________________ Date: ___________________

Tell us where you hurt.

Please read carefully:
Mark the areas on your body where you feel you rpain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache	> > > >	Numbness	= = = =	Pins and Needles	◯◯◯◯
Burning	x x x x	Stabbing	/ / / /	Throbbing	~ ~ ~ ~





Severity of Pain

List the region of pain.
Circle the severity number.
1=least pain, 10=greatest pain

ex: ________NECK________________
0 1 2 3 4 5 6 7 8 9 10

1. ______________________________
0 1 2 3 4 5 6 7 8 9 10

2. ______________________________
0 1 2 3 4 5 6 7 8 9 10

3. ______________________________
0 1 2 3 4 5 6 7 8 9 10

4. ______________________________
0 1 2 3 4 5 6 7 8 9 10

5. ______________________________
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.

Signature:_____________________________ Today's Date:___________

If the patient required assistance to complete information forms, please sign below and state your relationship to the patient.

Signature:____________________________ Relationship:_______________________
Date:______________

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:_____________________________ Today's Date:___________

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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.

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:________________________________ Today's 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/Guardian: __________________________ Signature: _________________________ Date:____________

Witness Name: __________________________ Signature: __________________________ Date: _____________