NEW HAMPSHIRE SPINE+SPORT

1650 Elm Street, Suite 301
Manchester, NH 03101
Tel: 603-203-3185 • nhspineandsport.com

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

REFERRED BY: _____

1. LAST NAME _____ FIRST NAME _____ 3. MI _____
4. ADDRESS _____
5. CITY _____ 6. STATE _____ 7. ZIP_____
8. HOME (_____) _____ 9. WORK (_____)_____ 10. CELL (_____) _____
11. AGE _____ 12. DATE OF BIRTH _____/_____/_____ 13. SEX ☐ M ☐ F 14. SOC. SEC.# _____-_____-_____
15. MARITAL STATUS S ☐ M ☐ D ☐ W ☐ 16. EMERGENCY CONTACT _____
17. EMER. CONTACT RELATIONSHIP _____ EMER. CONTACT PHONE (_____) _____
18. PRIMARY CARE PHYSICIAN:_____
ADDRESS:_____
TELEPHONE: (_____) _____ FAX: (_____) _____

WORKERS COMPENSATION / SCHEDULED LOSS INFORMATION

2. EMPLOYER & OCCUPATION _____
2. ADDRESS _____
3. CITY _____ 4. STATE _____ 5. ZIP _____
8. BUSINESS PHONE # (_____) _____ 9. FAX # (_____)_____
10. **(SCH. LOSS EXAMS)** DO YOU HAVE: ☐ SURGICAL REPORTS ☐ X-RAY REPORTS ☐ MRI REPORTS

AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION

1. INSURANCE TYPE: ☐ AUTO ☐ WORK ☐ LIEN ☐ _____
2. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
3. DATE OF INJURY _____ 4. DESCRIBE HOW INJURY OCCURED? _____
_____
6. WHICH BODY PART(S) WERE INJURED? _____
7. NAME OF INS. CO. _____ 8. INS. PHONE (_____)_____
9. INS. CO. ADDRESS _____
10. POLICY # _____ 11. CLAIM # _____ 12. WCB #_____
13. DID YOU REPORT INJURY? ☐ NO ☐ YES IF YES, TO WHOM?_____
14. HOSPITALIZED? ☐ NO ☐ YES WHERE?_____ 15. X-RAYS TAKEN ☐ NO ☐ YES BY WHOM _____
16. WHERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐ NO ☐ YES
17. ARE YOU PRESENTLY WORKING? ☐ NO ☐ YES IF NO, DATES LOST FROM WORK _____
18. NAMES OF OTHER DOCTORS SEEN FOR THIS INJURY _____
19. IF AUTO INJURY, WERE YOU? ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐_____
20. # OF PEOPLE IN YOUR VEHICLE? _____ 21. WORE SEAT BELT? ☐ NO ☐ YES 22. DID AIRBAG INFLATE ☐ NO ☐YES
23. NAME OF ATTORNEY _____
ATTORNEY ADDRESS:_____
ATTORNEY TELEPHONE: (_____) _____ ATTORNEY FAX: (_____) _____

PRIVATE HEALTH / MEDICARE INSURANCE INFORMATION

1. INSURED'S NAME _____ 2. INSURED'S SS# _____/_____/_____
3. PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ _____
4. NAME OF INSURANCE CO. _____
5. ADDRESS _____
6. INSURANCE PHONE # (_____)_____ 7. POLICY # _____
SECONDARY INSURANCE 8. INSURED'S NAME _____ 9. SS # _____/_____/_____
10. NAME IS INSURANCE CO. _____
11. ADDRESS _____
12. INSURANCE PHONE # (_____) _____ 8. POLICY # _____

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Confidential Patient Questionnaire

Name: Date:

Major Complaint(s):

CHECK YOUR PRESENT AND PAST SYMPTOMS

Present	Past		Present	Past	
☐	☐	Neck Pain	☐	☐	Excessive Thirst
☐	☐	Middle Back Pan	☐	☐	Chronic Cough
☐	☐	Low Back Pain	☐	☐	Sinus Problems
☐	☐	Headache	☐	☐	Chronic Fatigue
☐	☐	Dizziness	☐	☐	Painful Urination
☐	☐	Convulsions	☐	☐	Frequent Urination
☐	☐	Fainting, Visual Problems, Nausea	☐	☐	Difficulty with Bladder/Bowels
☐	☐	Shoulder Pain	☐	☐	Stomach Pain
☐	☐	Pain in Shoulder, Arms, Elbows	☐	☐	Difficult Swallowing
☐	☐	Pain in Hands	☐	☐	Depression
☐	☐	Pain in Upper Leg	☐	☐	High Blood Pressure
☐	☐	Pain in lower Leg	☐	☐	Angina
☐	☐	Pain in Ankle/Foot	☐	☐	Heart Attack
☐	☐	Swelling/Stiffness in Joints	☐	☐	Stroke
☐	☐	Jaw Pain	☐	☐	Asthma
☐	☐	Ringing in Ears	☐	☐	Cancer
☐	☐	Rapid Heart Beat	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Arthritis
☐	☐	Loss of Appetite	☐	☐	Diabetes
			☐	☐	Ulcers

Please describe your current pain: __ Sharp __Dull __ Aches __Sore __Weak __ Throbbing
__Shooting __Constricting __Burning __Tingling

Was your problem from a: __Car Accident __Work Related Injury __Started Gradually __Slip and Fall __Other

Describe how the problem began:

What treatment have you received for this condition: __Family Doctor __Chiropractic __ Physical Therapy
__Medical Specialist __Surgery __Injections __X-Ray __MRI Other_____

Have you ever had this problem before? __ Yes __No

What makes the problem better? __Nothing __ Lying Down __Walking __Sitting Other_____

What makes the problem worse? __Nothing __ Lying Down __Walking __Sitting Other_____

Are you currently working? __Yes __No
If yes, do you: ___Sit more then 50% of the day ___Light Manual Labor __Heavy Manual Labor

Does Your Problem Affect Your Daily Activities? __ No __Mild __Moderate __Significant Resretictions
Describe:

Do you Smoke? __No __Yes ___Packs per Day

Do you Drink Alcohol? __No __Socially __Habitually

Patient or Legal Guardian Signature

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Confidential Patient Questionnaire page 2

Are you Pregnant? __No __Yes Date of Onset of Last Menstrual Period _____

Are you Currently Taking Medication? ___No __Yes Please List all Medicaltions _____

_____

_____

Do you have Any Allergies to Drugs or Other Products? __No __Yes

Describe: _____

FAMILY HISTORY

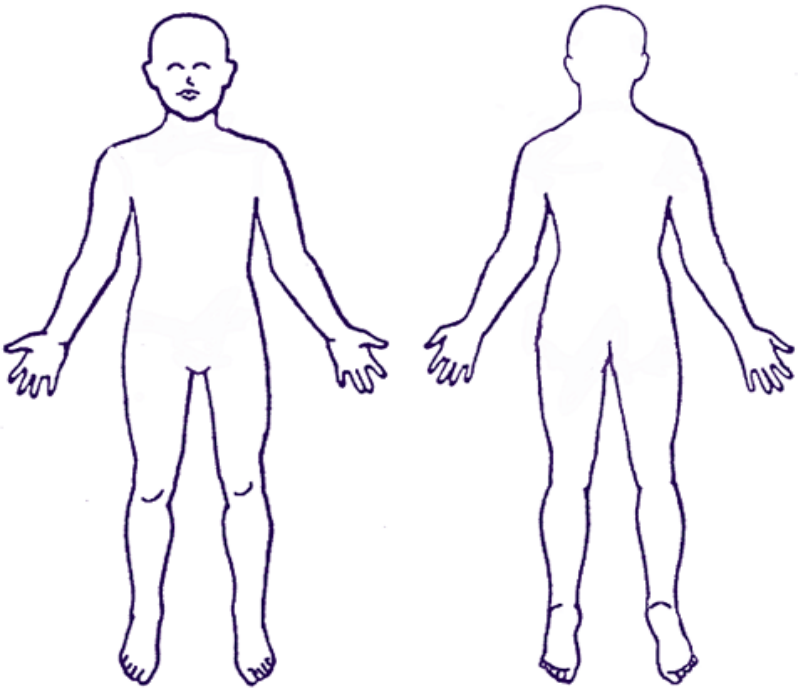
	Diabetes	Heart	Blood Pressure	Kidney	Cancer	Stroke	Other	
Mother	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	
Grandmother	☐	☐	☐	☐	☐	☐	☐	
Grandfather	☐	☐	☐	☐	☐	☐	☐	

Current Work Status:

☐ I Have Not Missed Any Days of Work
☐ I Have Missed ___ Days of Work
☐ I Have Been Put on Light Duty at Work
☐ I Have Had to Change my Job as a Result of my Condition

PAIN / SYMPTOM PICTURE

Please mark with an "X" where you have any symptoms



Patient or Legal Guardian Signature _____

Date: _____

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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:

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DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDER:
PATIENT:

Date:

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc. as necessary as it relates to the care being provided by my chiropractic doctor.

3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

5. I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.

6. I waive the Statute of Limitations regarding my doctor's right to recover from me directly.

7. I hereby acknowledge that I am receiving (or about to receive) health care services from _____ and am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or if I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

8. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all Court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's account.

Dated this_____day of _____, 20_____ _____

Patient's Signature

_____

Witness