

**Personal information**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone-home (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_ work (\_\_\_\_) \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex M F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Primary Care Physician - Name \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Payment Information**

I will not be using insurance and will be a self-paying patient \_\_\_\_\_

*signature*

**If using insurance please fill out below**

Insured's Name \_\_\_\_\_

Patient's relationship to Insured- \_\_\_self \_\_\_spouse \_\_\_child \_\_\_other

Name of Insurance Co. \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone (\_\_\_\_) \_\_\_\_\_ Policy # \_\_\_\_\_

*If visit is related to workers compensation:*

Claim # \_\_\_\_\_ WC Insurance Company: \_\_\_\_\_

Contact information \_\_\_\_\_

*If visit is related to an auto accident:* State where the accident occurred \_\_\_\_\_

Claim number: \_\_\_\_\_ Insurance company: \_\_\_\_\_

Contact Information \_\_\_\_\_

**Symptom questionnaire**

Your Name: \_\_\_\_\_

Describe the problem (s):

\_\_\_\_\_

When did this begin? \_\_\_\_\_

How did this begin? \_\_\_\_\_

Circle the number which describes how intense the pain is, with 10 being most intense:

0    1    2    3    4    5    6    7    8    9    10

What does the pain feel like (circle as many as necessary)?

Dull    Sharp    Achy    Stabbing    Electric    Tight    Stiff    Restricted

Do the symptom (s) travel to a different part of your body? If so, please describe:

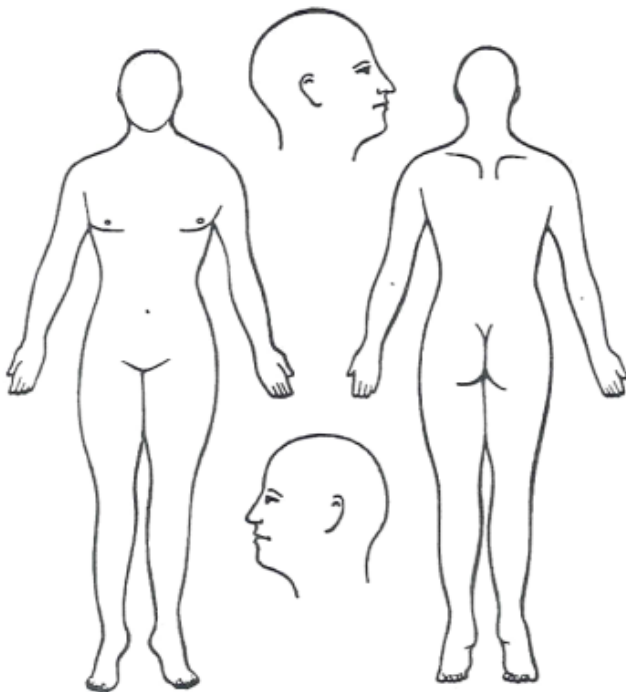
\_\_\_\_\_

What makes this problem worse? \_\_\_\_\_

What makes this problem better? \_\_\_\_\_

Is there a time of day when the problem changes: \_\_\_\_\_

Please mark or circle on the diagram where your symptom (s) occur:



Please list any:

Major injuries:

\_\_\_\_\_

Allergies:

\_\_\_\_\_

Medications:

\_\_\_\_\_

Ongoing illnesses:

\_\_\_\_\_

Do you smoke? No    Yes: pack(s)/day \_\_\_\_\_

History of surgeries: \_\_\_\_\_

**Do you have a family history of any of the following?** If so, please list which relative.

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart disease \_\_\_\_\_

Stroke \_\_\_\_\_

High blood pressure \_\_\_\_\_

Systemic arthritis \_\_\_\_\_

Connective Tissue disorders \_\_\_\_\_

Review of systems: *please circle any of the following you experience at present:*

<p><b>Constitutional</b></p> <p>Recent fever or infection</p> <p>Unexplained weight change</p> <p>Pain at night</p> <p>Fatigue</p> <p><b>Gastrointestinal</b></p> <p>Recent bowel changes</p> <p>Nausea</p> <p>Diarrhea</p> <p><b>Urinary</b></p> <p>Recent bladder changes</p> <p>Incontinence</p> <p>Urinary retention</p>	<p><b>Neurologic</b></p> <p>Headache</p> <p>Dizziness</p> <p>Seizures</p> <p>Inner thigh numbness</p> <p>Facial numbness</p> <p>Blurred or double vision</p> <p>Difficulty speaking or swallowing</p> <p><b>Cardiovascular</b></p> <p>Chest pain</p> <p>Irregular heartbeat</p> <p>Cough</p> <p>Shortness of breath</p>	<p><b>Low back</b></p> <p>Pain or Stiffness</p> <p><b>Neck</b></p> <p>Pain or Stiffness</p> <p><b>Lymphatic</b></p> <p>Swelling</p> <p>Unusual bleeding or bruising</p> <p><b>Extremities</b></p> <p>Arm pain or numbness</p> <p>Leg pain or numbness</p> <p><b>Skin</b></p> <p>Discoloration</p> <p>Rashes</p> <p><b>Circle if none apply</b></p>
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**DIRECT ASSIGNMENT OF BENEFITS & RIGHTS**

**Provider: Steven B. Baroody, DC 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 at 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 amount 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 **New Hampshire Spine and Sport** 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

### 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 “arterial dissection” that typically is 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, 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 a 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 circumstances. 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: \_\_\_\_\_