Back to Basics Chiropratic

Northwood Green 5 Northern Blvd. Unit 6 Amherst,NH

231 Main St. Comman Man Spa, Plymouth NH

New Patient Intake Form

About You

Last Name: _____ First Name: _____ Middle Initial: _____
Nickname:_____Date of Birth: _____ Age: _____ Gender: [ ] M [ ] F
Phone: (H)_____(W)_____(C) _____
Address:_____City: _____ State: _____ Zip: _____
E-Mail:_____ Occupation: _____
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other: _____
Names and Ages of Children: _____
Insurance: [ ] Work Comp [ ] Auto [ ] Medicare [ ] Private: _____
Emergency Contact: _____ Phone #: _____ Relationship: _____
Who may we thank for referring you to us? _____

Your Health Profile

As a family chiropractic office, we focus on your ability to be healthy. Our goals are first to addr ess the issues that brought you to this office, and second, to offer you the opportunity of improved health a nd wellness potential.

Describe the issues that brought you to our office: _____
_____
_____

If you have no symptoms or complaints and are here for **wellness services**, please check ☐

What are your health goals?
_____
_____
_____

Is your current condition the result of: [ ] an auto accident? [ ] a work related injury?
Date of injury? _____

Have you had previous chiropractic care? [ ] Y [ ] N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

Please describe below, in the following 2 sections, your primary and any additional reasons for seeking care in our office:

Primary complaint (List one only): _____

When did you first experience this problem?_____

If your complaint is the result of an injury, describe what happened? _____

_____

_____

How often do you experience this problem? [ ] 1-2x/week [ ] 3-4x/week [ ] 5-6 x/week [ ] daily
[ ] other: _____

On a scale of 0-10 with 10 representing the most severe pain imaginable, rate the average severity of your pain.
0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?
0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before? [ ] Y [ ] N

When?_____

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc.)? _____

_____

_____

Please describe the location of the pain: _____

_____

Does this problem cause pain to travel to any other area? [ ] Y [ ] N If yes, where?_____

_____

_____

Is this problem getting: [ ] worse? [ ] better? [ ] staying the same?

What seems to aggravate this problem? _____

_____

What have you tried to relieve this problem (i.e. interventions, treatments, medications, surgery)?

_____

_____

_____

Have you seen any other doctors for this problem? [ ] Y [ ] N If yes, who? _____

_____

What treatment was given? _____

How effective was the treatment? _____

Additional Complaints – (List *anything else you'd like to discuss with the doctor)*:

_____

When did you first experience this problem?_____

How did this problem first begin? _____

How often do you experience this problem? _____

When did these symptoms begin? _____

How would you describe the symptoms? _____

Please describe the location of the pain: _____

Is this problem getting: [ ] worse? [ ] better? [ ] staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem? _____

Have you seen anyone for this problem? If yes, who? _____

What treatment was given? _____

How effective was the treatment?_____

Lifestyle/Social History

What physical activities do you perform at work? (example: prolonged sitting, computer/desk, lifting, prolonged standing, etc…) _____

_____

_____

How many hours per week do you work? _____

What recreational activities/hobbies do you regularly engage in? _____

_____

_____

Do you smoke cigarettes? [ ] Y [ ] N If yes, how much? _____

Do you drink alcohol? [ ] Y [ ] N If yes, how much? _____

Do you drink coffee? [ ] Y [ ] N If yes, how much? _____

Do you drink tea? [ ] Y [ ] N If yes, how much? _____

How regularly do you exercise? [ ] daily [ ]_____x/week [ ] occasionally [ ] never

What kind of exercise do you do?_____

How many hours of sleep do you get on average?_____

On a scale of 0-10 please rate your stress level (0=none and 10=extreme):

Occupational _____

Personal _____

Medical History

Please check any of the following illnesses you have had:

_____Anemia	_____Diabetes	_____Lyme	_____Rheumatic Fever
_____Arthritis	_____Eczema	_____Pneumonia	_____Mental Disorders
_____Cancer	_____Epilepsy	_____Polio	_____Tuberculosis
_____Chicken Pox	_____Heart Disease	_____Small Pox	_____Thyroid Disorder

Surgeries:

Date	Type and reason for surgery
_____	_____
_____	_____
_____	_____
_____	_____

Accidents or Injuries:

Date	Details
_____	_____
_____	_____
_____	_____
_____	_____

Medications & Supplements	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

_____

_____

Women Only

Pregnancies and outcomes:

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

Are you pregnant? [ ] Yes [ ] No [ ] Not sure

Medical History

Please check any of the following you have experienced in the **past 6 months**:

MUSCULO-SKELETAL
_____Low Back Pain
_____Pain Between Shoulders
_____Neck Pain
_____Arm Pain
_____Headaches
_____Joint Pain/Stiffness
_____Walking Problems
_____Difficult Chewing/Clicking Jaw
_____General Stiffness

NERVOUS SYSTEM
_____Nervous
_____Numbness
_____Paralysis
_____Dizziness
_____Forgetfulness
_____Confusion/Depression
_____Fainting
_____Convulsions
_____Cold/Tingling Extremities
_____Stress
_____Hearing Difficulty

GASTRO-INTESTINAL
_____Poor/Excessive Appetite
_____Excessive Thirst
_____Frequent Nausea
_____Vomiting
_____Diarrhea
_____Constipation
_____Hemorrhoids
_____Liver Problems
_____Gall Bladder Problems
_____Weight Trouble
_____Abdominal Cramps
_____Gas/Bloating after Meals
_____Heartburn
_____Black/Bloody Stools
_____Colitis

GENITO-URINARY
_____Bladder Trouble
_____Painful/Excessive Urination
_____Discolored Urine

CARDIO-VASCULAR-RESPIRATORY
_____Chest Pain
_____Short Breath
_____Blood Pressure Problems
_____Irregular Heartbeat
_____Heart Problems
_____Lung Problems/Congestion
_____Varicose Veins
_____Ankle Swelling
_____Stroke

EENT
_____Vision Problems
_____Dental Problems
_____Sore Throat
_____Ear Aches
_____Stuffed Nose

MALE/FEMALE
_____Menstrual Irregularity
_____Menstrual Cramps
_____Vaginal Pain/Infection
_____Breast Pain/Lumps
_____Prostate/Sexual Dysfunction
_____Other Problems:
_____
_____
_____

GENERAL
_____Fatigue
_____Allergies
_____Headaches
_____Fever

Please give us any other health information you may feel would be helpful: _____
_____
_____

Authorizations and Releases

Patient's name:_____Date of Birth: _____

Authorization and Agreement for Payment of Services Rendered:

I authorize Back to Basics Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claims for reimbursement of charges incurred by me.

I understand that I am responsible financially for my bill. If Back to Basics Chiropractic bills my insurance I am reponsible for any unpaid balance.

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient's signature:_____Date: _____

Informed Consent for Examination and Treatment

This document explains some potential risks associated with chiropractic care. Please read this information carefully, and let our staff know if you have questions.

Back to Basics Chiropractic will do everything to assist you with your health, or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. Nor do we offer advice regarding a previous diagnosis or treatment prescribed by others.
While Chiropractic care is remarkably safe, there are some risks associated with it, and we feel you need to be fully informed about these risks before consenting to treatment.

Soreness – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please advise your doctor if you experience this.
Soft Tissue Injury – Rarely, Chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.
Rib Injury – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.
Stroke – Stroke is the most serious complication of Chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of this type of stroke is one in five million neck adjustments.
Other Complications – There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctor and Back to Basics Chiropractic to perform examination, procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian.
I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

Patient's signature:_____Date:_____
(Parent or guardian, if patient under age 18)