Raymond Chiropractic Clinic

151 Rt. 27 Raymond, NH 03077

Today's Date:____/____/_____ Email Address:_____

Name:_____Home Phone:_____Cell Phone:_____

Home Address:_____

Birthdate:_____ Age:_____ Social Sec.#:_____Insurance #:_____

Parent/Guardian (if minor):_____Single___Married___Divorced___Separated_____

Employer:_____Type of Work:_____Work Phone:_____

Name of Spouse:_____Spouse's Work/Cell #:_____

Referred to this office by:_____Emergency Contact Name/Number:_____

CURRENT HEALTH CONDITION

Purpose of this appointment:_____

Other Doctors seen for this condition: Yes No Who?:_____

Type of treatment:_____Results:_____

When did this condition begin?:_____ Has this condition occurred before?: Yes No

Is Condition: ____Job Related ____Auto Accident____Fall____Home Injury____Other:_____

Date of Accident:_____ Have you filed an accident report to employer/or insurance?_____

PAST HEALTH HISTORY

Major Surgery/Operations:_____

Major Accidents or Falls:_____

Hospitalization (Other than above):_____

I authorize the doctor to provide any and all forms of treatment, evaluation, x-rays and therapy that may be indicated in connection with the care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he sees fit. I understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor. I agree to pay for all services rendered in this office.

Signature:_____Date:_____Relationship to Patient:_____

Raymond Chiropractic Clinic

TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING…

Place appropriate symbol or letter on the diagram.

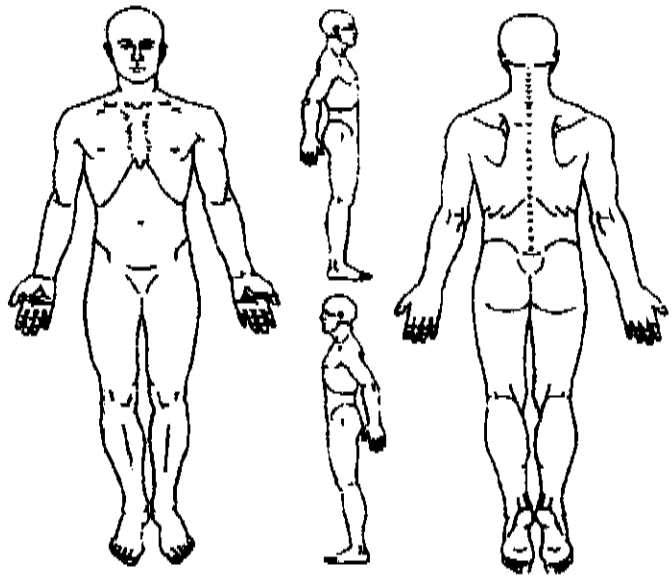
Ache = AAAAA
Numbness = NNNNN
Pins and Needles = OOOOO
Burning = XXXXX
Stabbing = / / / / /

WHAT IS THE INTENSITY OF YOUR PAIN?

Please circle one…

Slight **Minimal**

Moderate **Severe**



VISUAL ANALOG PAIN SEVERITY SCALE

Please place a mark on the line that corresponds to your *current* pain.

NO PAIN WORSE PAIN EVER

Please place a mark on the line that corresponds to your *average* pain.

NO PAIN WORSE PAIN EVER

When did the pain begin? _____ Any flare-ups since then? If so, when? _____

What brought the pain on? _____

What makes the pain better? _____

What makes it worse? _____

How often does the pain exist? _____ And for how long? _____

Any prior injuries to the area of pain? _____

Have you seen another healthcare practitioner for the pain/condition? _____

If so, who? _____

Have you had any X-rays taken of the body or the area of complaint in this past year? _____

Please bring these (or at least the report) with you to your appointment? _____

Patient Name: _____ Date: _____

Have you ever been treated by a chiropractor? Yes _____ No _____

Clinic or Doctor's name: _____

Clinic phone number: _____

Are you taking any of the following medications? _____ Nerve Pills _____ Pain Killers (including aspirin)

_____ Muscle Relaxers _____ Blood Thinners _____ Tranquilizers _____ Insulin _____ Other

Do you or have you had any of the following dieases, medical conditions or procedures?

Y N Heart Attack/Stroke	Y N Heart/Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Venereal Disease
Y N Hepatitis	Y N Anemia/Diabetes	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Glaucoma	Y N Kidney Problems	Y N High/Low Blood Pressure
Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe/Frequent Headaches	Y N Tuberculosis
Y N Ulcers/Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema/Asthma
Y N Arthritis	Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems
Y N Artificial Bones/Joints/Implants			

Please list any surgeries with dates and/or any other serious medical condition not listed above: _____

_____

List any past serious accidents with dates: _____

_____

Please list any allergies: _____

Family health history: _____

_____

Do you take supplements/vitamins? ____ Yes ____ No Do you exercise? ____ Yes ____ No _____ hours/week

Do you smoke? ____ Yes ____ No How much? _____ How long? _____

Are you wearing: ____ Shoe lifts ____ Inner Soles ____ Arch Supports

Are you dieting? ___ Yes ___ No Since: _____/_____/_____

For Women: Are you taking birth control? ___ Yes ___ No

Are you nursing: ____ Yes ____ No Are you pregnant: ____ Yes ____ No If so, how many weeks? _____

I guarantee that this form was filled out to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I provided:

Signature: _____ Date: _____/_____/_____

____ Adult Patient ____Parent or Guardian ____ Spouse

Gary A. Graham, D.C.
RAYMOND CHIROPRACTIC CLINIC
151 ST., ROUTE 27
RAYMOND, NH 03077
TELEPHONE: (603) 895-0077

Patient Consent Form

I understand, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, Plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* the possible uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Dr. Graham has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care options, I also understand you are not required to agree to my requested restrictions, but if you do you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Office use only

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practice*, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____