



**Chiropractic Associates**  
**765 South Main Street, Suite 201**  
**Manchester, NH 03102**

WELCOME TO OUR OFFICE

Today's Date: \_\_\_/\_\_\_/\_\_\_ E-mail Address: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Parent/Guardian (if minor): \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed

Medical Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone#: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_  
Street City State Zip Code

Occupation: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

**Insurance Information**

Was this injury work related? \_\_\_\_\_ Automobile Accident? \_\_\_\_\_

Insurance Company: \_\_\_\_\_

**For All Patients**

I hereby 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 (s)he sees fit. I also 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: \_\_\_\_\_

*Thank you for choosing CHIROPRACTIC ASSOCIATES for your healthcare.*



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If you are *not* here to seek Wellness Care on this visit and have pain,  
please mark on the diagram the type of pain and location:

**TYPE OF PAIN YOU ARE CURRENTLY EXPERIENCING...**

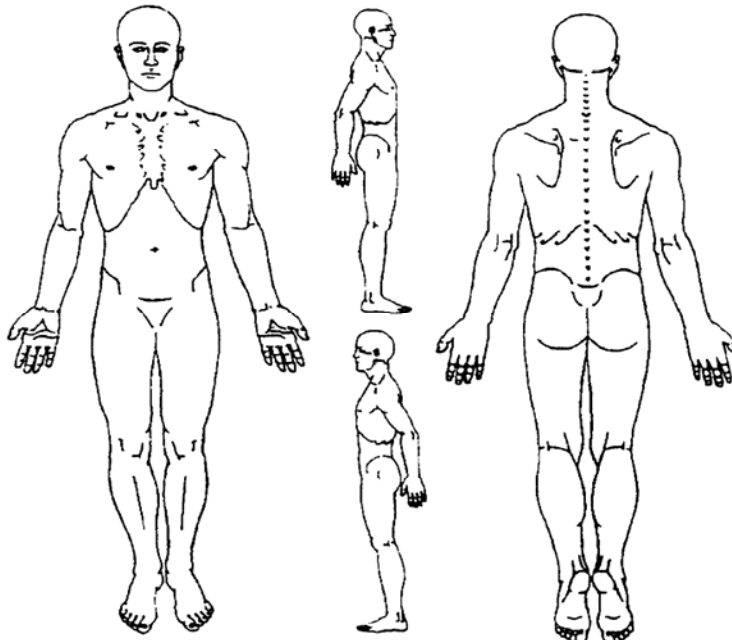
Place appropriate symbol or letter on the diagram.

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

**WHAT IS THE INTENSITY OF YOUR PAIN?**

Please circle one...

<b>Slight</b>	<b>Minimal</b>
<b>Moderate</b>	<b>Severe</b>



**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? \_\_\_\_\_



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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 diseases, 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



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**FORM: NOTICE OF PRIVACY PRACTICE SUMMARY**

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Chiropractic Associates uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Chiropractic Associates will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Chiropractic Associates may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Chiropractic Associates may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Dr. Thomas Pratt and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Chiropractic Associates must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms and of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Dr Thomas Pratt at (603) 626-3900.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date