

PERSONAL HISTORY

Name: _____ SS#: _____
 Address: _____ Birth Date: _____ Age: _____ Sex: M / F
 City: _____ State: _____ Zip: _____ Circle: Single Married Widowed Divorced
 Home Ph: _____ Cell Ph: _____ E-Mail: _____
 Referred to this Office by: _____
 Employer: _____ Job Position: _____
 Work Ph: _____ Ext # _____ Work Activities: _____
 Your Insurance Company: _____ (If no insurance, please write "self pay")
 Policy Holders Name: _____ Policy Holders Birth Date: _____
 Policy Holders Employer: _____ Policy # _____
 Your Relationship to Policy Holder: (Circle) Spouse Self Child Calendar or Contract Year Policy?
 Secondary Insurance? _____ If so, Name of Secondary Insurance: _____
 Emergency Contact: _____ Phone # : _____

CURRENT HEALTH CONDITION

Purpose of this Office Visit (Chief Complaint): _____
 On a scale of 1-10, 10 being the worst pain, how would you rate your pain? _____
 When did this condition begin? _____ Has it occurred before? Yes / No
 How did this condition begin? _____ Have you been using ice/heat since the injury?
 Other Doctors seen for this condition? Yes / No If Yes, Who? _____
 Type of Treatment: _____ Results: _____
 Is Condition: (Circle) Job Related Auto Accident Home Injury Fall Workers Comp Other _____
 Date of Accident: _____ Time of Accident: _____
 Is it getting progressively worse? Yes / No Does it affect your: Work ___ Sleep ___ Daily Routine ___
 Is your pain: (Circle) Occasional Intermittent Frequent Constant?
 Does the pain radiate? Yes / No If Yes, how far does it radiate? _____
 What activities aggravate this condition? _____
 What relieves this condition? _____
Any other complaints other than your chief complaint? _____
 On a scale of 1-10, 10 being the worst pain, how would you rate your pain? _____
 When/How did this condition begin? _____ Has it occurred before? Yes / No
 Other Doctors seen for this condition? Yes / No If Yes, Who? _____
 Type of Treatment: _____ Results: _____

 Medications you take: Pain Killers / Muscle Relaxers ___ Nerve Pills ___ Blood Pressure ___ Insulin ___
 Birth Control ___ Over the Counter Meds ___ Other: _____
 Do you wear a shoe lift? Yes / No Orthotics? Yes / No Are you: Right Handed ___ Left Handed ___
 Do you wear a seatbelt? Always ___ Never ___ Sometimes _____

PAST HEALTH HISTORY

Please list and give dates for:

Major Surgeries: _____

Disc Herniation: _____

Broken Bones: _____

Major Accidents or Falls: _____

Previous Chiropractic Care? Yes / No When was your last visit? _____ Dr. Name:

Names and ages of Children: _____

Females Only:

List Dates and Types of Childbirth: _____

CONSENT FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during, the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. I have also been offered a copy of the office privacy policy.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(signature)

(date)

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema |

INTAKE

- Coffee/Tea
 Drugs
 Alcohol
 Cigarettes
 Exercise
 Sleep
 Appetite

	HEAVY	MODERATE	LIGHT	NONE

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| NEVER | OCCASIONAL | FREQUENT | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain Between Shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arm Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain/Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Walking Problems <input type="checkbox"/> Feet <input type="checkbox"/> Knee <input type="checkbox"/> Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficult Chewing/Clicking Jaw |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | General Stiffness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| NEVER | OCCASIONAL | FREQUENT | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gas/Bloating After Meals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Black/Bloody Stool |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colitis |

FEMALES ONLY:

When was your last period? _____

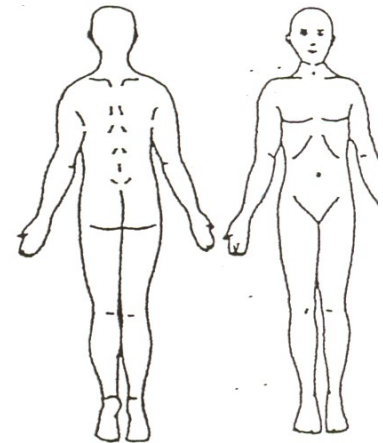
Are you pregnant?
 Yes No Not Sure

GENITO-URINARY CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful/Excessive Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Discolored Urine |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed-Wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Trouble |

C-V-R CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Short Breath |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood Pressure Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems/Congestion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ankle Swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |



Please outline on the diagram the area of your discomfort

NERVOUS SYSTEM CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Forgetfulness |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Confusion/Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cold/Tingling Extremities |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stress |

GENERAL CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|---------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily |

GASTRO-INTESTINAL CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Poor/Excessive Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Weight Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Cramps |

EENT CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vision Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sore Throat |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear Aches |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stuffed Nose |

MALE/FEMALE CODE

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Irregularity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Menstrual Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vaginal Pain/Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast Pain/Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prostate/Sexual Dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

FAMILY HISTORY:

List the health status and age of the following:

- | | | |
|--------------------------|-----------|-------|
| <input type="checkbox"/> | Mother | _____ |
| <input type="checkbox"/> | Father | _____ |
| <input type="checkbox"/> | Brother 1 | _____ |
| <input type="checkbox"/> | Brother 2 | _____ |
| <input type="checkbox"/> | Sister 1 | _____ |
| <input type="checkbox"/> | Sister 2 | _____ |

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS: _____ DIAGNOSIS: _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize _____ Insurance Company to pay by check made out and mailed directly to:

**Dr. Donna L. Splendore
211 Loudon Road, Suite G
Concord, NH 03301**

the medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay in a current manner any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check out to me and mail it as follows:

**c/o Dr. Donna L. Splendore
211 Loudon Road, Suite G
Concord, NH 03301**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Date: _____ 20____

Signature of Policyholder

Signature of Claimant