Nault Chiropractic, P. C. New Patient Questionnaire

Patient Information (Please Print)

Name: _____ Age_____ SS#_____
Address: _____ City _____ State___ Zip _____
Marital Status: Single Married Divorced Other Sex: □ Male □ Female
Birthdate:_____ Home Phone #: _____ Cell #: _____
E-Mail Address: _____
Employment Status: Full Time Part Time Student Unemployed Retired
Occupation:_____
Whom may we thank for referring you to us? _____
Name of Primary Physician:_____
Primary Care Phone #(if known):_____ Address(if known):_____

SYMPTOMS

Primary Complaint: _____
Getting worse? Yes / No Is the pain constant? Yes / No Getting better? Yes / No
When did it start? _____ What activity bothers it the most? _____
Rate the pain - (0 is pain free -10 is unbearable pain): 1 2 3 4 5 6 7 8 9 10
Secondary Complaint: _____, Other _____
Have you ever been to a Chiropractor? Yes / No Positive Experience? Yes / No
Height (if known):_____ Weight (if known):_____ Blood Pressure (if known):_____/_____

Health History – Please circle all that apply

AIDS/HIV	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma	Bleeding
Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts	Chicken pox	Depression	Diabetes
Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea	Gout	Heart dx
Hepatitis	Hernia	Herniated disc	Herpes	High Cholesterol	Kidney dx	Liver dx	Measles
Migraines	Miscarriage	Mono	M.S.	Mumps	Osteoporosis	Parkinson's	Polio
Pacemaker	Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	V.D.	Whooping cough	
Chronic Fatigue	High Blood Pressure	Fibromyalgia					

Other _____

Previous Surgeries and Dates?(continue on back)_____
List Medications you are currently taking (continue on back) :_____
Allergies to Medications(continue on back):_____
What kind of exercise do you do? _____
Smoking Status(circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked
Alcohol Drink(s) per week?_____

Women – Pregnant? Yes / No If yes, how many weeks? _____ How many children? _____

Insurance Information – If Insured, Please provide copy of Insurance card

I authorize- this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office and payable benefits.

Informed Consent

I have decided that it is in my best interest to receive Chiropractic examination and treatment. I hereby give my consent to the examination and treatment. I intend for this consent to cover the entire course of examination and treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____

Optional Information

Race(circle one): American Indian or Alaska Native / Asian / Black or African American / White / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity(circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Additional Surgeries and Dates:_____

_____

Additional medications:

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Additional allergies:

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries include current diagnosis, medications and allergies but most often are blank as a result of the nature and frequency of chiropractic care.)*

Nault Chiropractic, P. C.
33 Oak Avenue
Worcester, MA 01605
(508) 438-1444

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice is effective as of the Date you signed the acknowledgement that you have received this notice.
This notice will expire seven years after the date upon which the record was created.

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal representative printed	Personal representative signature

Description of personal representative's authority to act for the patient.

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Doctor Name: Dr. Stephen J. Nault

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, supportive therapies, etc. on me by the doctor of chiropractic named above and/or other assistants.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic examination and treatments. Those complications include but are not limited to: disc injury, sprain/strain injuries, and joint separations.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of my chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic examination and treatments. I state that I have been informed and weighed the risks involved in chiropractic care at this health care office. I have decided that it is in my best interest to receive chiropractic examination and treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of examination and treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date