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
116 Belmont St.
Worcester MA 01605

Patient Name:
Patient D.O.B.:
Patient Number:

Informed Consent for Chiropractic Services

I have been informed of the following:

1. I have been informed that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
2. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
3. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury;
4. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
5. I have been informed that certain techniques may require close proximity between clinician and patient;
6. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
7. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
8. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment; and
9. I have been afforded ample opportunity for questions and answers.

Therefore, by signing below:

I **consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I **consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Guardian Name (if applicable):_____

Guardian Signature (if applicable):_____ Date:_____

Witness Signature:_____ Date:_____

NAULT CHIROPRACTIC
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AUTHORIZATION: The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENT: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Patient Name Printed	Date
Patient Signature	Authorized Provider Rep.
Personal Representative Printed	Personal Rep. Signature

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