Welcome to our practice!

Patient Information

Thank you for choosing Goffstown Chiropractic Care, PLLC for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(please print clearly)

Name: _____ Social security number: _____

Address: _____ City: _____ State: _____ Zip code: _____

Sex: ❑ Female ❑ Male Date of birth: _____ E-mail: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

I prefer to receive appointment reminders via: ❑ E-mail ❑ Cell phone text – my carrier is _____

❑ Married ❑ Widow(er) ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient employer/school: _____ Occupation: _____

Employer/school address: _____ City: _____ State: _____ Zip code: _____

Spouse or parent's name: _____ Employer: _____ Work phone: (_____)_____

Who may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account: _____ Social security number: _____

Relationship to patient: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip code: _____

Name of employer: _____ Phone: (_____)_____

Insurance Information

Insurance company name: _____ Phone: (_____)_____

Name of insured person (if other than patient): _____ Their date of birth: _____

Relationship of insured to patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insurance policy number: _____ Insurance group number: _____

Insurance policy: ❑ Health ❑ Medicare ❑ Automobile ❑ Worker's compensation

Claim number if accident or injury: _____ Date of accident or injury: _____

Name of insurance case worker (if accident/injury): _____ Phone: (_____)_____

Accident/injury is related to: ❑ Employment ❑ Automobile ❑ Other _____

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Light ❑ Moderate ❑ Heavy Type: _____

What do your daily work habits include? _____

What vitamins/nutritional supplements do you currently take? _____

_____

Do you smoke? ❑ Never ❑ Former smoker ❑ Occasional smoker ❑ Current smoker How much per day? _____

Do you drink alcoholic beverages? ❑ No ❑ Beer ❑ Wine ❑ Liquor How much per week? _____

How many caffeinated beverages do you consume daily? _____ Type: _____

How would you rate your overall health? ❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

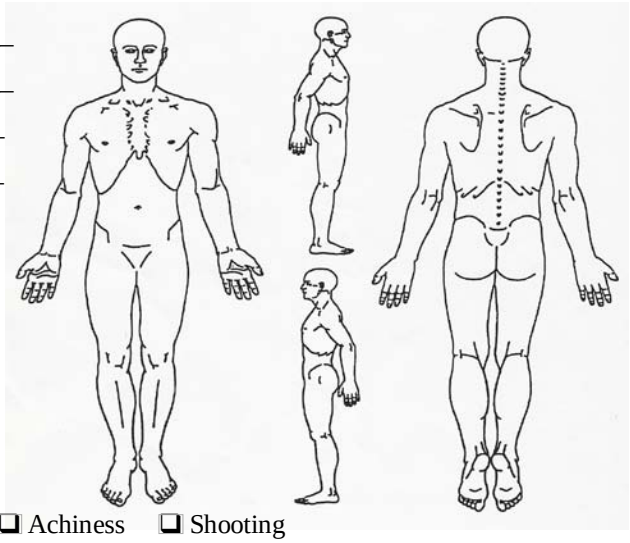
*Symptoms*_____

Reason for visit: _____

When did you first notice your symptoms? _____

How do you think your symptoms began? _____

_____



Indicate on the drawings to the right where you have pain/symptoms:

How often do you experience your symptoms?

❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Infrequently (1-25% of the time)

How are your symptoms changing with time?

❑ Getting worse ❑ Staying the same ❑ Getting better

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Achiness ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other: _____

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What aggravates your condition? _____

What makes your condition better? _____

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Chiropractic ❑ Physical therapy ❑ Massage ❑ None ❑ Other _____

How much has your condition interfered with your work and social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

Do you consider your condition to be severe? ❑ Yes ❑ Yes, at times ❑ No

What concerns you the most about your condition? What does it prevent you from doing? _____

Health History *Check only those conditions which are applicable:* _____

❑ Headaches
❑ Neck pain
❑ Upper back pain
❑ Mid back pain
❑ Low back pain
❑ Shoulder pain
❑ Elbow/arm pain
❑ Wrist pain
❑ Hand pain
❑ Hip pain
❑ Upper leg pain
❑ Knee pain
❑ Ankle/foot pain
❑ Jaw pain
❑ Joint pain/stiffness
❑ AIDS/HIV
❑ Alcoholism
❑ Allergy shots
❑ Anemia
❑ Anorexia
❑ Appendicitis
❑ Arthritis
❑ Asthma
❑ Blood disorder
❑ Breast lump
❑ Bronchitis
❑ Bulemia
❑ Cancer
❑ Cataracts
❑ Chemical dependency
❑ Chicken pox
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Fractures
❑ Glaucoma
❑ Goiter
❑ Gonorrhea
❑ Gout
❑ Heart disease
❑ Hepatitis
❑ Hernia
❑ Herniated disc
❑ Herpes
❑ High cholesterol
❑ Kidney disease
❑ Liver disease
❑ Measles
❑ Migraines
❑ Miscarriage
❑ Mononucleosis
❑ Multiple sclerosis
❑ Mumps
❑ Osteoporosis
❑ Pacemaker
❑ Parkinson's disease
❑ Pinched nerve
❑ Pneumonia
❑ Polio
❑ Prostate problems
❑ Psychiatric care
❑ Prosthesis
❑ Rheumatoid arthritis
❑ Scarlet fever
❑ Stroke
❑ Thyroid problem
❑ Tonsillitis
❑ Tuberculosis
❑ Tumor/growth
❑ Typhoid fever
❑ Ulcers
❑ Whooping cough
❑ Other: _____
_____

List any surgeries/hospitalizations you have had and dates which they occurred: _____

_____

List any traumas/motor vehicle accidents/fractures you have had and dates which they occurred: _____

_____

Health History, continued

Please list all medications you are currently taking: _____

_____

Allergies: _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Family History

Indicate if you have any family members with a history of the following:

❑ Rheumatoid arthritis ❑ Diabetes ❑ Lupus ❑ ALS ❑ Thyroid condition
❑ Heart Problems ❑ Cancer ❑ Stroke ❑ Seizures ❑ Other: _____

Motor Vehicle Accident *(if applicable)*

Date of accident: _____ Time of accident: _____

How and where did the accident happen? _____

Where were you sitting at the time of the accident? _____

Please mark the following that apply at the time of the accident:

❑ Wearing seat belt ❑ Air bag deployed ❑ Body hit interior of car ❑ Ejected from vehicle ❑ Lost consciousness
❑ Unaware of impending collision ❑ Aware of impending collision and relaxed ❑ Aware of impending collision and tightened up

What happened after the accident?

❑ Police arrived ❑ Ambulance arrived ❑ Taken by ambulance to hospital ❑ Police report written
❑ Refused treatment ❑ Drove to hospital ❑ Went to doctor's office ❑ Other: _____

Immediately after the accident, where did you feel pain/symptoms? _____

Currently where do you feel pain/symptoms? _____

Other treatment received for this accident: _____

Worker's Compensation Injury *(if applicable)*

Date of injury: _____ Time of injury: _____

How and where did the injury happen? _____

What happened after the injury?

❑ Continued working ❑ Stopped working ❑ Notified supervisor ❑ Incident report written
❑ Drove to hospital ❑ Went to doctor's office ❑ Received no treatment ❑ Other: _____

Immediately after the injury, where did you feel pain/symptoms? _____

Currently where do you feel pain/symptoms? _____

Are you currently working? ❑ Yes, without restrictions ❑ Yes, with restrictions ❑ No

Other treatment received for this injury: _____

Patient Payment Agreement

Our policy requires payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the doctor. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to my health record.

Signature _____ Date _____