

Crosser Chiropractic & Natural Health Center

73 Wakefield Street
Rochester, NH 03867
603.332.3232

CONFIDENTIAL PATIENT INFORMATION

Name _____ Age _____ Birth date _____ SS# _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

E-mail: _____ Marital: M S W D P # of children _____ Name of Spouse _____

Occupation _____ Employer _____ Bus. Phone _____

Business Address _____ City _____ State _____ Zip _____

Referred by _____

Name of person responsible for payment _____ Their Address (if different from above) _____

_____ City _____ State _____ Zip _____ Phone _____

Primary Care Physician's Name _____ City _____ Last Visit there _____

Was this condition caused by a (1) Work Situation [] Y [] N, (2) Auto Accident [] Y [] N, has your work or auto insurance been notified? [] Y [] N

Is there a Lawyer involved? If so their Name _____ City _____ State _____

Are you Insured [] Y [] N Company _____ *Please give receptionist your card to be copied*

Reason for this Appointment (describe) _____

What treatment options are you interested? Adjusting by hand Chiropractic, Instrument adjusting chiropractic (less intense)

In addition, are there other treatment options you are interested in? Meridian Therapy Vitamins/Herbs Dietary/Food Colon Hydrotherapy

What do you hope to accomplish with this appointment? _____

Describe the type of pain, frequency of pain, and use the diagram to mark the location of pain using appropriate symbols. _____

What aggravates the condition: sitting, walking, getting up from sitting, getting out of bed, bending forward, twisting Other, describe _____

What relieves the condition: sitting, walking, sleeping, cold pack, heat, stretching, Other, describe _____

Are there other things affected? ie sleeping, eating, using the bathroom, more heartburn, more ringing in the ears, more dizziness, diarrhea, constipation, Others, describe _____

What date did this begin _____

Have you had a similar condition before? [] Y [] N, if yes when _____

What caused this episode to happen? Describe _____

Have you seen other doctors for this? [] Y [] N

If yes, Name of Doctor _____ Other Doctor _____

Dates of Visit: _____

Tests done: _____

Diagnosis: _____

Treatment: _____

Results: _____

Has your condition been getting [] worse [] better [] staying the same [] variable

Have you been doing any self treatment? [] heat [] cold pack [] stretching [] Advil [] tylenol [] vitamins [] other, describe _____

Are you under a doctor's care for other conditions? If yes, describe with the condition, the doctors name, and the treatment.

- 1. _____
2. _____
3. _____
4. _____

Are you taking any other medications? [] Y [] N If yes, please describe _____

Please list the vitamins or herbs you take: _____

Do you have any permanent physical or mental disability not described? [] Y [] N, if yes describe _____

List any past significant illnesses or accidents not listed above (with dates) _____

List any past operations with dates, not listed above _____

Do you currently have any of these symptoms?

- [] AM Headaches [] PM Headaches [] Dizziness [] Sciatica [] Numbness in Hand
[] Ringing in Ears [] Diarrhea [] Constipation [] Tingling in Hand [] Groin pain
[] Numbness in Feet [] Restless Sleep [] Tingling in Feet [] Groin pain

Have you had any of the following?

- [] Cancer [] Heart condition [] Stroke [] Colitis [] Diabetes
[] Fibromyalgia [] Food Allergies [] Asthma [] Other Allergies

Please read and sign: I understand that my insurance is a contract between me (the patient) and my insurance company, and I am liable for services rendered in this office if the insurance companies refuses to pay for any reason.

Patients Signature: _____ Date _____

Guardian or Spouses signature authorizing care _____ Date _____

Please answer the following questions we are required to ask per new Government HIPPA regulations:

- [] Y [] N May we call you with appointment reminders, and leave that information on your answering machine or with those that might answer the phone other than you?
[] Y [] N May we e-mail you with appointment reminders, information about your treatment, or other health related information that may be of interest to you?
[] Y [] N May we mail you appointment reminders, information about your treatment, or other health related information that may be of interest to you?
[] Y [] N May we let others know you are a patient in our office?

Notes concerning the above

I authorize Crosser Chiropractic & Natural Health Center to do that in which I have authorized above:

Signed _____ Date: _____

Cerv ROM: _____ Thoracic ROM: _____ Lumbar ROM: _____

Rt S-I ROM: _____ Lt S-I ROM: _____ SSLR: +rt +lt

Motion Palpation restrictions noted: | | | | | | | | |

Spinal Manipulation direction: | | | | | | | | |

Other Treatments: _____

Suggestions: _____

