



NASHUA FAMILY CHIROPRACTIC

29 Riverside Street, Units A and B, Nashua, NH 03062

P: (603) 880-4150

F: (603) 880-6765

Mission: *"To raise the vibration of everyone who walks through our door."*

Vision: *"To revolutionize healthcare in our community."*

Welcome! We look forward to helping you to meet your health goals. Please take a few minutes to fill out this questionnaire to help us to serve you better.

Name: _____ Today's Date: _____

Address: _____ DOB: _____

City/Town: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail address: _____

Best way to reach you: _____

Is it acceptable to leave a message at this number: _____

Would you like to be added to our e-mail list? Yes _____ No _____

If yes, you will receive an invitation to the email address provided.

You must click "Subscribe" to receive the newsletters.

Would you like to be added to our mailing list? Yes _____ No _____

Would you like us to send you a text message for your appointment reminder?

Yes, please! _____ No, Thank you. _____ What is your cell phone carrier? _____

How did you learn about our clinic and services?

Telephone book _____ Internet _____ if so, what site? _____

Doctor (please name) _____

Friend/personal referral (name, if desired) _____

Insurance provider list _____ Other _____



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Financial Policy

Payment is expected at time of visit. It may be made by cash, check, or credit card.

Acupuncture is a Flexible Spending Account or Health Savings Account eligible expense, and payment may be made via FSA/HSA account card with a Visa or MasterCard logo.

Insurance will be billed as applicable by this office, but you are ultimately responsible for payment for all services. Many insurance companies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

If your level of coverage is uncertain we require that you pay \$20 towards today's charges and \$20 on each following visit. Your full portion of the bill is expected when payment is received from your insurance carrier. If you have a specific contracted amount for copayment that amount is due each visit.

Any unpaid balances will be considered past due 30 days following treatment or insurance reimbursement, which ever come last. Past due balances may have an interest charge of 1.5% applied per month.

By signing this form you are authorizing this office, upon request from your insurance carrier, the release of any medical or other information necessary to process the claim.

By signing this form you are authorizing payment of medical benefits be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately will be personally responsible for payment regardless of your insurance coverage.

Your appointment time is reserved for you. If you cannot make your scheduled appointment, this office requests 24hrs notice. **Failure to provide such notice will result in a \$35 late cancelation fee. A No Show/Call will result in a \$50 fee.**

Your understanding is greatly appreciated.

I have read and agree to the above:

Printed Name : _____

Date: _____

Signature : _____

SSN: _____



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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in the office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent at any time during care but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Date: _____ Patient name (printed): _____

Patient signature: _____



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Health History Questionnaire

Today's Date: _____

Name: _____ Sex: _____ DOB: _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Height: _____ Weight: _____

Occupation: _____

Family Physician: _____

Emergency Contact: _____ Relationship: _____

Emergency contact phone number: _____

What is the main problem you would like help with? _____

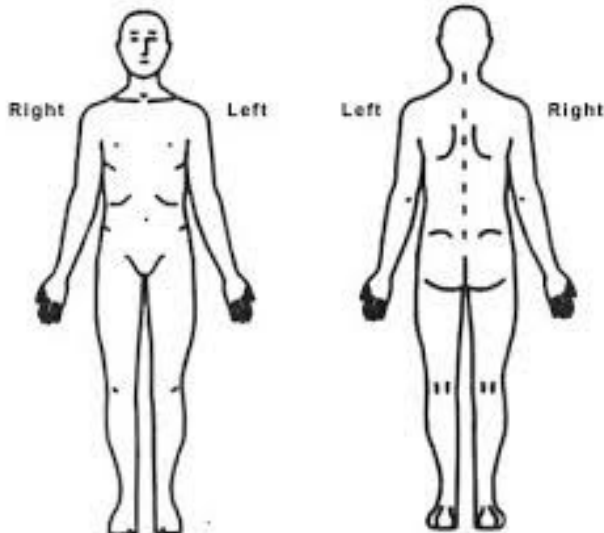
When did this problem begin? _____

To what extent does this problem interfere with your activities of daily living, work, sleep or sex life? _____

Have you been given a diagnosis for this problem? _____ If so, what? _____

What other treatments have you tried for this problem? _____

Have you ever been treated by acupuncture or Oriental medicine before? _____



Mark the areas of your body where you feel the described sensation. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X Numbness
+ Burning
*** Pin & Needles**
= Stabbing



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Name: _____ DOB: _____

Past medical history:

Have you been diagnosed with any of the following? (circle all that apply):

Cancer	Diabetes	High blood pressure	Heart disease	Asthma
Seizures	Venereal disease	Thyroid disease	Hepatitis	Stroke

Other (please specify): _____

Surgeries: _____

Significant traumas (motor vehicle accidents, falls, bone fractures, etc.): _____

Allergies: _____

Medications you now take, including over the counter and herbal supplements:

Occupational stress (chemical, physical or emotional): _____

Do you have a regular exercise routine? If yes, please describe: _____

Have you ever been on a restricted diet? If yes, please describe: _____

Please describe your average daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you smoke? If so, how much: _____

How many caffeinated beverages do you consume daily: _____

How much water do you drink daily? _____

How much alcohol do you drink? _____



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Name: _____ DOB: _____

Do you use any drugs for non-medical purpose? If so, please describe: _____

Please circle if you have had any of the following in the last 3 months:

General:

- | | | |
|---------------------|--------------------------|--------------------------------------|
| Fever | Peculiar taste or smells | Strong thirst (hot or cold drinks) |
| Sweat easily | Cravings | Poor sleep |
| Night sweats | Change in appetite | Fatigue |
| Chills | Weight loss | Sudden drop in energy (time of day?) |
| Bleed/bruise easily | Weight gain | |

Skin and hair:

- | | | |
|--|-------------|--------------|
| Rashes | Ulcerations | Hives |
| Itching | Eczema | Acne |
| Dandruff | Hair loss | Recent moles |
| Change in skin or hair texture: _____ | | |
| Any other skin or hair problems? _____ | | |

Head, eyes, ears, nose, throat:

- | | | |
|--|-----------------|------------------------|
| Dizziness | Concussions | Migraines |
| Glasses | Eye strain | Eye pain |
| Poor vision | Night blindness | Color blindness |
| Cataracts | Blurry vision | Spots in front of eyes |
| Ringling in ears | Poor hearing | Earaches |
| Sinus problems | Nose bleeds | Recurrent sore throat |
| Grinding teeth | Facial pain | Sores on lips/in mouth |
| Teeth problems | Jaw clicks | Headaches |
| Any other head or neck problems? _____ | | |

Cardiovascular:

- | | | |
|---|----------------------|---------------------------|
| Chest pain | Fainting | Blood clots |
| Phlebitis | Irregular heart beat | Cold hands or feet |
| High blood pressure | Low blood pressure | Peripheral Artery Disease |
| Swelling of hands | Swelling of feet | Varicose veins |
| Any other heart or blood vessel problems: _____ | | |



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Respiratory:

Asthma	Shortness of breath	Difficulty breathing
Cough	Coughing blood	Pain with deep breath
Bronchitis	Pneumonia	Wheezing

Difficulty breathing while lying down

If you are producing phlegm, what color is it? _____

Any other lung or breathing problems: _____

Gastrointestinal:

Nausea	Vomiting	Heartburn/indigestion
Diarrhea	Constipation	Blood in stools
Rectal pain	Hemorrhoids	Gas
Belching	Bloating	Bad breath
Bleeding gums	Chronic laxative use	

Any other problems with your stomach or intestines: _____

Urinary:

Frequent urination	Painful urination	Kidney stones
Urgency to urinate	Blood in urine	Incontinence
Wake up to urinate	Decrease in flow	

What color is your urine: _____

Any other problems with your urinary system? _____

Male reproductive:

Impotence	Premature ejaculation	Spermatorrhea
Testicular pain	Testicular injury	Prostatitis
Prostate Cancer	Benign Prostatatic Hypertrophy	
Low sperm count	Low motility	
Sore on genitals	STDs	

Any other reproductive problems? _____

Female reproductive:

Are you pregnant? _____

Is it possible you are pregnant? _____

Age of first menses: _____ Duration of menses: _____

Time between menses: _____



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Name: _____ DOB: _____

Number of pregnancies: _____ Number of live births: _____

Number of premature births: _____ Miscarriages: _____

Abortions: _____ Age of menopause: _____

When was your last GYN exam? _____

Do you practice birth control? If so what and for how long? _____

Do you have:

Breast lumps

Vaginal discharge

Sores on genitals

Irregular periods

Painful periods

Heavy bleeding

Light bleeding

Infertility

STDs

Western Infertility Treatment

Changes in body or psyche prior to menstruation? _____

Any other reproductive problems? _____

Musculoskeletal:

Neck pain

Hand/wrist pain

Foot/ankle pain

Shoulder pain

Hip pain

Muscle pain

Back pain

Knee pain

Muscle weakness

Any other muscle, joint or bone problems? _____

Neurological:

Seizures

Stroke

Concussion

Dizziness

Numbness

Tremors (where?)

Loss of balance

Poor memory

Lack of coordination

Any other neurological problems? _____

Psychological:

Depression

Anxiety

Fearful

Sadness

Easily angered

Easily worried

Easily susceptible to stress

Overly joyful

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other psychological problems? _____

If there is anything you wish to bring to our attention that has not been asked on this form, please mention it here. _____