Confidential Patient History **Splendore Family Chiropractic** **Date:_____**

PERSONAL HISTORY

Name:_____ SS#:_____

Address:_____ Birth Date:_____ Age:____ Sex: M / F

City:_____State:____ Zip: _____ Circle: Single Married Widowed Divorced

Home Ph:_____Cell Ph:_____ E-Mail:_____

Referred to this Office by:_____

Employer:_____ Job Position:_____

Work Ph:_____Ext #_____ Work Activities:_____

Your Insurance Company:_____(If no Insurance, please write "self pay")

Policy Holders Name:_____Policy Holders Birth Date:_____

Policy Holders Employer:_____Policy #_____

Your Relationship to Policy Holder: (Circle) Spouse Self Child Calendar or Contract Year Policy?

Secondary Insurance?_____If so, Name of Secondary Insurance:_____

Emergency Contact:_____ Phone # :_____

CURRENT HEALTH CONDITION

Purpose of this Office Visit (Chief Complaint):_____

On a scale of 1-10, 10 being the worst pain, how would you rate your pain?_____

When did this condition begin?_____Has it occurred before? Yes / No

How did this condition begin?_____Have you been using ice/heat since the injury?

Other Doctors seen for this condition? Yes / No If Yes, Who?_____

Type of Treatment:_____Results:_____

Is Condition: (Circle) Job Related Auto Accident Home Injury Fall Workers Comp Other_____

Date of Accident:_____Time of Accident:_____

Is it getting progressively worse? Yes / No Does it affect your: Work___Sleep___Daily Routine___

Is your pain: (Circle) Occasional Intermittent Frequent Constant?

Does the pain radiate? Yes / No If Yes, how far does it radiate?_____

What activities aggravate this condition? _____

What relieves this condition?_____

Any other complaints other than your chief complaint?_____

On a scale of 1-10, 10 being the worst pain, how would you rate your pain?_____

When/How did this condition begin?_____Has it occurred before? Yes / No

Other Doctors seen for this condition? Yes / No If Yes, Who?_____

Type of Treatment:_____Results:_____

_____

Medications you take: Pain Killers / Muscle Relaxers___ Nerve Pills___ Blood Pressure___ Insulin___

Birth Control___ Over the Counter Meds___ Other:_____

Do you wear a shoe lift? Yes / No Orthotics? Yes / No Are you: Right Handed____ Left Handed___

Do you wear a seatbelt? Always_____ Never_____ Sometimes_____

PAST HEALTH HISTORY

Please list and give dates for:

Major Surgeries:_____

Disc Herniation:_____

Broken Bones:_____

Major Accidents or Falls:_____

Previous Chiropractic Care? Yes / No When was your last visit?_____Dr. Name:

Names and ages of Children:_____

Females Only:

List Dates and Types of Childbirth:_____

CONSENT FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during, the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. I have also been offered a copy of the office privacy policy.

I,_____have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(signature) (date)

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

	HEAVY	MODERATE	LIGHT	NONE
Coffee/Tea				
Drugs				
Alcohol				
Cigarettes				
Exercise				
Sleep				
Appetite				

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

NEVER	OCCASIONAL	FREQUENT	
☐	☐	☐	Low Back Pain
☐	☐	☐	Pain Between Shoulders
☐	☐	☐	Neck Pain
☐	☐	☐	Arm Pain
☐	☐	☐	Joint Pain/Stiffness
☐	☐	☐	Walking Problems ☐ Feet ☐ Knee ☐ Hip
☐	☐	☐	Difficult Chewing/Clicking Jaw
☐	☐	☐	General Stiffness
☐	☐	☐	Arthritis
☐	☐	☐	Shoulder Pain

NERVOUS SYSTEM CODE

☐	☐	☐	Numbness
☐	☐	☐	Paralysis
☐	☐	☐	Dizziness
☐	☐	☐	Forgetfulness
☐	☐	☐	Confusion/Depression
☐	☐	☐	Fainting
☐	☐	☐	Convulsions
☐	☐	☐	Cold/Tingling Extremities
☐	☐	☐	Stress

GENERAL CODE

☐	☐	☐	Fatigue
☐	☐	☐	Allergies
☐	☐	☐	Loss of Sleep
☐	☐	☐	Fever
☐	☐	☐	Headaches
☐	☐	☐	Bruise Easily

GASTRO-INTESTINAL CODE

☐	☐	☐	Poor/Excessive Appetite
☐	☐	☐	Excessive Thirst
☐	☐	☐	Frequent Nausea
☐	☐	☐	Vomiting
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Hemorrhoids
☐	☐	☐	Liver Problems
☐	☐	☐	Gall Bladder Problems
☐	☐	☐	Weight Trouble
☐	☐	☐	Abdominal Cramps

NEVER	OCCASIONAL	FREQUENT	
☐	☐	☐	Gas/Bloating After Meals
☐	☐	☐	Heartburn
☐	☐	☐	Black/Bloody Stool
☐	☐	☐	*Colitis*

GENITO-URINARY CODE

☐	☐	☐	Bladder Trouble
☐	☐	☐	Painful/Excessive Urination
☐	☐	☐	Discolored Urine
☐	☐	☐	Bed-Wetting
☐	☐	☐	Prostate Trouble

C-V-R CODE

☐	☐	☐	Chest Pain
☐	☐	☐	Short Breath
☐	☐	☐	Blood Pressure Problems
☐	☐	☐	Irregular Heartbeat
☐	☐	☐	Heart Problems
☐	☐	☐	Lung Problems/Congestion
☐	☐	☐	Varicose Veins
☐	☐	☐	Ankle Swelling
☐	☐	☐	Stroke

EENT CODE

☐	☐	☐	Vision Problems
☐	☐	☐	Dental Problems
☐	☐	☐	Sore Throat
☐	☐	☐	Ear Aches
☐	☐	☐	Hearing Difficulty
☐	☐	☐	Ringing in Ears
☐	☐	☐	Stuffed Nose

MALE/FEMALE CODE

☐	☐	☐	Menstrual Irregularity
☐	☐	☐	Menstrual Cramps
☐	☐	☐	Vaginal Pain/Infection
☐	☐	☐	Breast Pain/Lumps
☐	☐	☐	Prostate/Sexual Dysfunction

☐ Other Problems

☐ _____

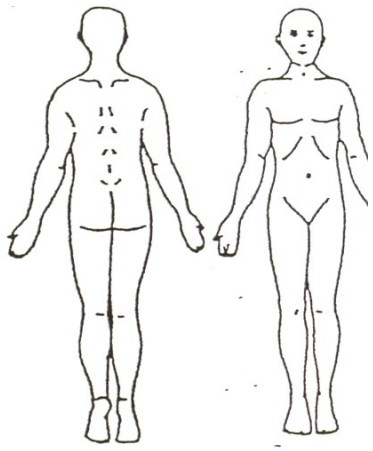
☐ _____

☐ _____

FEMALES ONLY:

When was your last period? _____

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram t
area of your discomfort

FAMILY HISTORY:

List the health status and age fo
the following:

- ☐ Mother _____
- ☐ Father _____
- ☐ Brother 1 _____
- ☐ Brother 2 _____
- ☐ Sister 1 _____
- ☐ Sister 2 _____

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS: _____ DIAGNOSIS: _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize_____Insurance Company to pay by check made out and mailed directly to:

Dr. Donna L. Splendore
211 Loudon Road, Suite G
Concord, NH 03301

the medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay in a current manner any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby authorize you to make the check out to me and mail it as follows:

c/o Dr. Donna L. Splendore
211 Loudon Road, Suite G
Concord, NH 03301

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

Date:_____20___

_____
Signature of Policyholder

_____
Signature of Claimant