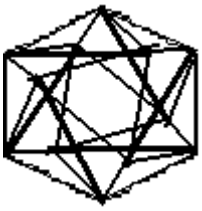
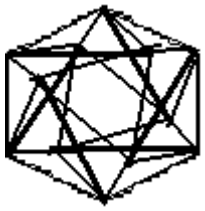




Artful Chiropractic

Phone: (603) 203-3185 • **Fax:** (603) 626-6950
40 South River Road, Unit 54, Bedford, N.H. 03110

Dr. Steve Baroody

Patient Information Sheet

Date: _____ Name: _____
Address: _____
City: _____ State/Zip: _____
Cell Phone: (_____) _____ - _____ Social Security Number: _____
In case of emergency, contact: _____ Phone: (_____) _____-_____
Birthdate: ____/____/_____ Male: _____ Female: _____
mo dy yr
Height: _____ Weight: _____ Shoe Size: _____
Please list your hobbies, sports, and other interests:
_____
_____

Work Information
Position: _____
Employer: _____ Supervisor: _____
Employer Address: _____
Phone at work: (_____) _____ - _____ ext _____

Physician Information
Name of Primary Physician: _____
Address: _____
Phone: (_____) _____-_____

Visit Information
Referral by: _____
What is the reason for your visit today? _____
_____

Insurance Information
Insurance Company:_____
Providers Services Phone: _____ Name of Insured: _____
Insured Date of Birth: _____ Relationship to Patient: _____

Is your condition due to an accident _____ or illness _____?
If an accident, did it occur at work? _____ Date of accident: _____

Artful Chiropractic
Phone: (603) 626-6950 **Fax:** (603) 626-6955
Dr. Steve Baroody
40 South River Road, Unit 54, Bedford, N.H.03110

Patient to complete the following sections:

Patient Last Name:	First Name:	MI:	Daytime Phone:
Date:	SS Number:		Evening Phone:

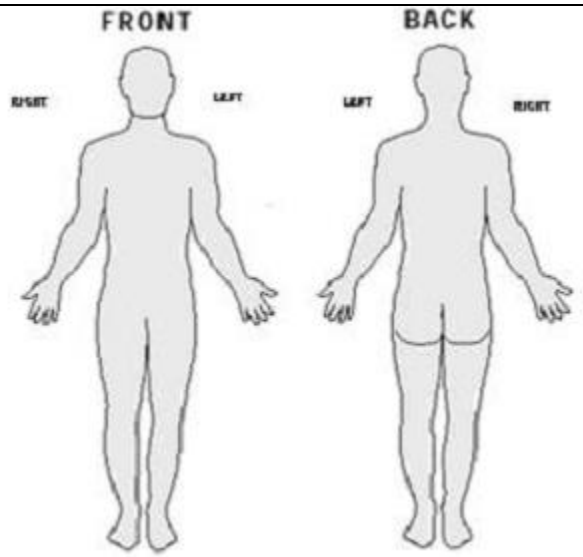
Please list the reasons/condition for your visit in order of importance, most important at the top:	Date you first noticed:	Pain &/or Symptoms Circle the number that best reflects your condition: (0= no effect 10= severe)	Pain &/or Symptoms Circle how much of the time your experience your condition:
A.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
B.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
C.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%
D.		0 1 2 3 4 5 6 7 8 9 10	25% 26-50% 51-75% 76-100%

For each condition listed above, please indicate how it happened:

A. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
B. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
C. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know
D. ❑ Developed over time ❑ Illness ❑ Injury ❑ Auto accident ❑ Other _____ ❑ I don't know

For each condition listed above, please indicate if it is better or worse with any of the following:

	Heat	Cold	Rest	Activity	Other:_____
A.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
B.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
C.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse
D.	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse	❑ Better ❑ Worse



Please mark the areas of your discomfort on the figures at right, using the symbol which best describes the feeling: +++ sharp, stabbing; 000 pins & needles; VVV dull, aching; /// numbness

Please indicate if your condition limits any of the following activities:

Activity	Normal	Somewhat Limited	Severely Limited
Lifting _____			
Bending _____			
Standing _____			
Walking _____			
Sitting _____			
Climbing stairs _____			
Running _____			
Resting _____			
Intercourse _____			
Computer work/typing _____			
Normal work _____			
Household activities _____			
Recreational activities _____			
Other _____			

Comments:

Please Continue to Next Page…

Patient to complete the following sections:

Artful Chiropractic Dr. Steve Baroody
Phone: (603) 626-6950 **Fax:** (603) 626-6955 40 South River Road, Unit 54, Bedford, N.H.03110

Last Name: First Name:	Date:

During what time of day do you feel worst? _____
Do you sleep well? Yes ❑ No ❑
What are your normal sleeping hours? _____
Are you currently under the care of a medical doctor or other health care provider for any condition?
Yes ❑ No ❑ Condition: _____
Name of doctor/provider: _____ Phone: _____
Have you ever had an overnight stay in a hospital or surgical procedure of any kind? Yes ❑ No ❑
Date and Description: _____
Date and Description: _____
Do you exercise? Yes ❑ No ❑
Description: _____ Frequency/Minutes per session: _____
Description: _____ Frequency/Minutes per session: _____

Personal History:

Please read through the following list and check any which may apply to you

•Pain in Body•
__Neck pain with difficulty swallowing
__Extreme neck stiffness with pain or electrical shocks in arms or legs when moving neck
__Leg pain that worsens with exercise but is relieved by resting
__Loss of feeling in inner thighs
__Back pain with urinary problems

•Current Conditions•
__Unable to balance properly
__Recent unexplained weight loss
__Recent progressive muscle weakness or shaking
__Blurred or double vision, dizziness, nausea or faintness when neck is in certain position
__Recent major accident such as a fall from a height, whiplash, or a blow to the head
__Memory loss after injury

•Types of Pain•
__Severe pain interrupts sleep
__Constant pain not improved by changing positions or lying down

•Prior diagnosed condition/Medical History•
__Congenital bone or joint disorder
__Rheumatoid arthritis
__Severe degenerative arthritis
__History of compression fracture
__History of heart attack
__History of stroke or aneurysm
__Past history of cancer or currently diagnosed with cancer
__Diabetes with cold, burning, or numb feet
__Gout
__Lupus
__Ankylosing spondylitis
__Immune suppression due to chemotherapy, organ transplant, etc.
__3 or more months use of steroid medications or intravenous drugs (past or recent)

Family History

Please read through the following list and check any which apply to you.

__Autoimmune Disorders __Cancer __Heart Disease __Mental Illness
__Arthritis __Diabetes __Kidney Disease __Seizure Disorder

Based on all the things you do to cope, or deal with, your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. Remember, you can circle only one number along the scale.

No control Some Complete control
0 1 2 3 4 5 6 7 8 9 10

Based on all the things you do to cope, or deal with, your pain, on an average day, how much are you able to decrease it? No control Some Complete control
0 1 2 3 4 5 6 7 8 9 10

How confident are you in your ability to overcome your problem?
Total confidence No confidence
0 1 2 3 4 5 6 7 8 9 10

Artful Chiropractic Dr. Steve Baroody
Phone: (603) 626-6950 **Fax:** (603) 626-6955 40 South River Road, Unit 54, Bedford, N.H.03110

Notice of Privacy Practices

The **Health Insurance Portability and Accountability Act** concerns the security of your personal and medical information. We respect your privacy and rights, so we follow these guidelines as applicable to our practice. A partial list of **your rights** includes but is not limited to allowing (or prohibiting) health care providers from **revealing information with your permission, as necessary**, to others involved in your health care, such as insurance carriers, physicians, home care aides, and family members, friends, or other health care proxies who share responsibility for your well-being or billing for services rendered. **Information** includes but is not limited to medical records, diagnostic reports, treatments, tests and results, billing, and referrals, as well as personal data such as birth date, etc. **We will coordinate** with all parties necessary for prompt, accurate and effective treatment and proper billing. **We will gladly explain** all aspects of your care to you or assigned persons as you wish.

Name: (printed) _____Signature: _____ Date:_____

Release of Information

I certify that the above information is true and correct to the best of my knowledge. I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above other health care professionals to whom I am referred and to the insurance carrier or other entity responsible for payment, utilization and/or quality review for all or a portion of my care and treatments.
Today's date: _____ *Signature of patient:* _____
If patient required assistance to complete information forms, please sign below and state your relationship to the patient.
Today's date: _____ *Signature:* _____ *Relationship to patient:* _____

Cancellation Policy

In consideration to your fellow patients, we ask that you give us 24 hours notice of all cancellations and rescheduling. In the event that you do not, we reserve the right to charge you $40 for the missed appointment. Please note, this fee is ***not covered*** by your insurance. Signature: _____ Date: _____

Lien

In consideration for services rendered by Dr. Steven Baroody, d/b/a Artful Chiropractic, I,_____, agree that I am responsible for payments of all co-payments, deductibles, coinsurance and charges for services not covered by my insurance policy or from another payment source (for example: workers compensation, legal settlement, medicare, etc.). I agree to present an insurance card, if applicable, so that Dr. Steven Baroody, d/b/a Artful Chiropractic can make every effort to notify my insurance company that I am a patient of Dr. Baroody, in order to obtain authorization, if necessary.

I make this statement with the full knowledge and understanding that I am responsible for payments and any debt incurred may result in legal proceedings against me by Dr. Steven Baroody, d/b/a Artful Chiropractic. I accept responsibility for this and hereby authorize this establishment to perform any and all necessary services at this time.

Signature: _____ Date: _____