

Artful Chiropractic

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1650 Elm St. Suite 301 Manchester, NH 03101

Dr. Steve Barody

Patient Information Sheet

Date: _____ Name: _____

Address: _____

City: _____ State/Zip: _____

Cell Phone: (____) _____ - _____ Social Security Number: _____

In case of emergency, contact: _____ Phone: (____) _____ - _____

Birthdate: ____/____/____ Male: _____ Female: _____

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Height: _____ Weight: _____ Shoe Size: _____

Please list your hobbies, sports, and other interests:

How did you hear about us? _____

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 & phone number: _____

Name of Insured: _____ Insured date of birth: _____

Policy Number: _____ Relationship to Patient: _____

Is your condition due to an accident _____ or illness _____?

If an accident, did it occur at work? _____ Date of accident: _____

Patient to complete the following sections:

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

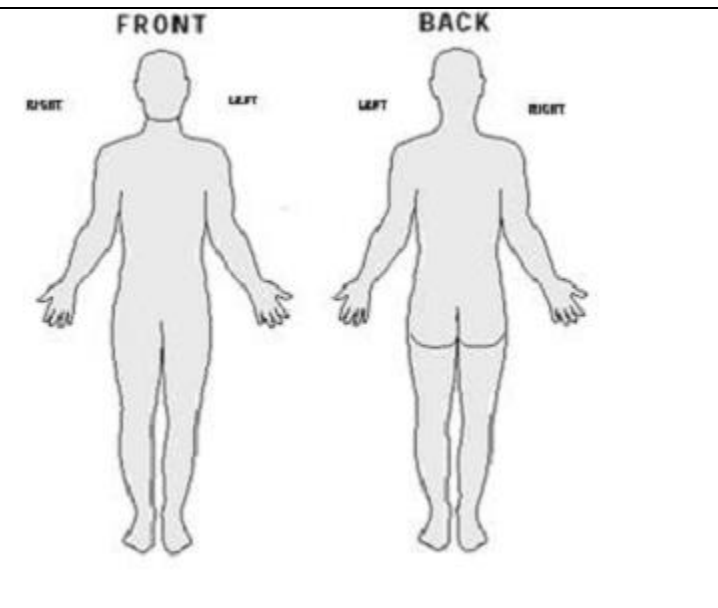
Please list the reasons/condition for your visit in order of importance, most important at the top:	Date you first noticed:	Pain &/or Symptoms Circle the number that best reflects your condition: (0= no effect 10= severe)	Pain &/or Symptoms Circle how much of the time your experience your condition:
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. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| B. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| C. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse |
| D. | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> Worse | <input type="checkbox"/> Better <input type="checkbox"/> 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:

	Normal	Somewhat Limited	Severely Limited
Activity			
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:

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 0 1 2 3 4 5 6 7 8 9 10 Complete control

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 0 1 2 3 4 5 6 7 8 9 10 Complete control

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

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: _____

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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: _____