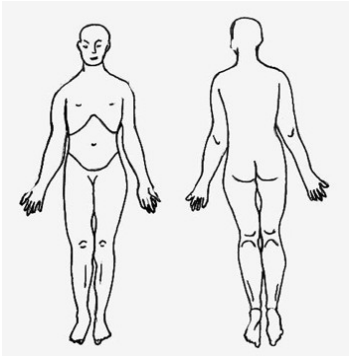


Jaffrey Chiropractic Health Center – New Patient Intake Form

Date _____ Name _____
Address _____ City _____ State _____ Zip _____
E-Mail _____ Referred By _____
Home Phone _____ Work Phone _____ Cell Phone _____
Age _____ Birth Date _____ Marital: S M W D How many children? _____
Occupation _____
Employer _____ Address _____
Emergency Contact _____ Phone _____ Other Phone _____

CONFIDENTIAL HEALTH HISTORY

Please outline your discomfort.



Please describe your present complaints:

Who has treated you for this condition (if anyone)? _____

Date of Last Physical _____ Have you been treated for any other health condition in the last year? YES NO

Describe _____

Are you taking any medications? YES NO

If yes, please list _____

Is this a work related injury? YES NO

When did your present complaints occur? _____

Is this condition interfering with your Work: Dates missed _____ Sleep Recreation

Have you had this condition or similar conditions in the past? YES NO If so, when? _____

What treatment did you receive? _____

Name & location of previous chiropractor: _____

Approximate date of last chiropractic treatment: _____

If any of the following have happened to you at any time, give approximate dates & briefly describe injury:

Auto accidents: _____ Spine or neck injuries: _____

Falls or other injuries: _____ Knocked unconscious: _____

Broken bones: _____ Other: _____

Surgeries: _____ Health problems of parents: _____

Please check any of the following that apply to your current/past medical history:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Polio | <input type="checkbox"/> Dentures | <input type="checkbox"/> Eczema/Hives |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of sleep |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sprained ankle | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Vomiting of blood | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Depression | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Low backache | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Painful tailbone | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Hardening of arteries | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Surgery | <input type="checkbox"/> Numbness in arms/hands |
| <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Stiff or painful neck | <input type="checkbox"/> Weakness in arms | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Bad posture | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Burning sensations | |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Enlarged Glands | | |
| <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Gout | | |
| <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Nasal congestion | | |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Itching | | |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Chronic cough | | |
| <input type="checkbox"/> Poor urine control | <input type="checkbox"/> Heart disease | | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Hemorrhoids | | |
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Cancer | | |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Belching or gas | <input type="checkbox"/> Chest pain | | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Vomiting | | |
| <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Broken bones | | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Weakness in legs | | |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Rheumatic fever | | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sinus infection | | |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Convulsions | | |

For Women Only:

- | | |
|---|---|
| <input type="checkbox"/> Premenstrual tension | <input type="checkbox"/> Unable to get pregnant |
| <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Excessive flow | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Tubal ligation | <input type="checkbox"/> Lumps in breast |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Irregular cycle |

Is there a possibility that you may be pregnant? YES NO

Date of last menstrual period _____

PAYMENT/INSURANCE INFORMATION – (If applicable, please have your insurance card available to photocopy)

Person Responsible For Payment

Name _____ Phone _____ DOB _____

Address _____ City _____ Zip _____

Are you Insured? YES NO Insurance Company _____

Policy Holder _____ Date of Birth _____

Policy Holder's Employer _____

Assignment of Benefits

I hereby authorize _____ (Insurance Co) to pay by check made out and mailed to: **Joshua J. Joaquin, D.C.** (at Jaffrey Chiropractic, 24 Main Street, Jaffrey, NH 03452) the medical and surgical 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 to me and mail it to the above address.

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.

Financially Responsible Party's Signature _____ Date _____