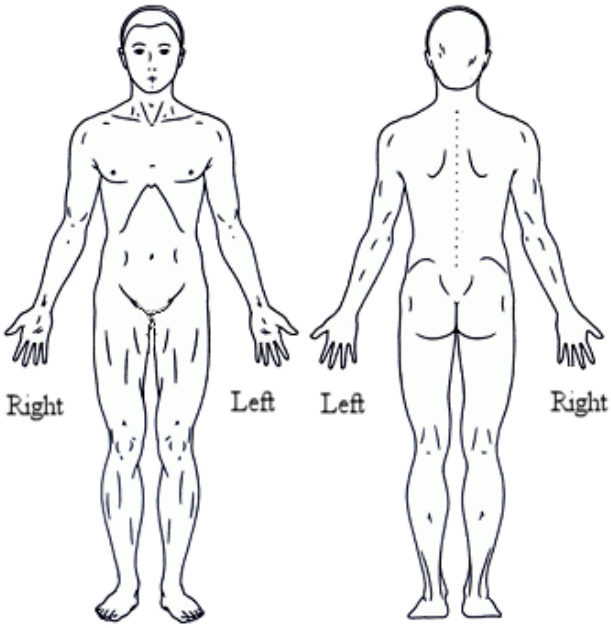
Northeastern Chiropractic

Name _____Age _____Date _____
Address _____ City _____ State_____ Zip_____
Phone _____ Date of Birth _____ Sex: M F Marital Status: S M
Occupation/Employer _____
How did you hear about us? _____

Insured's Name _____ Insured's Date of Birth _____

Complaint due to an accident? __ Yes __ No __ Auto Accident __ Date of accident_____

HEALTH REPORT:
Reason for seeking care:
_____



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N Morning Afternoon Night
Is this condition interfering with:
Work?_____Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse, staying the same, or better? _____

List any other doctors seen for this: _____
List any known diagnosis and type of treatment: _____
Have you received chiropractic treatment previously? __ Yes __ No
If yes, explain:
_____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
List the approximate dates of any surgery or treated conditions: _____
_____

Family History:

Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____

PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice for Northeastern Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office on my first visit.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____
Patient Signature Date

_____
Print Name

I authorize Northeastern Chiropractic to text me appointment reminders.

Cell Phone Number: _____

Signature: _____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins
__ clots/clotting syndrome

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature_____Date_____

Informed Consent

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr. Vanessa Arnold and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Vanessa Arnold, including those working at Northeastern Chiropractic LLC, whether signatories to this form or not.

I have had an opportunity to discuss with Dr. Vanessa Arnold and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature Date

_____

Patient Print Name

_____

Signature of Parent or Guardian (if patient is a minor)