NORTHEAST LIFESTYLE MEDICINE

Welcome to Northeast Lifestyle, LLC.

Today's Date: _____/_____/ _____ E-mail Address: _____

Name: _____ Social Security #: _____-_____-_____

Phone #'s: (H)_____ (W)_____ (C)_____

Home Address: _____
Street City State Zip Code

Birthdate: _____/_____/_____ Age: _____ Parent/Guardian (if minor): _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Medical Physician: _____ Physician Phone #: _____

Nearest relative not living with you: _____ Phone #: _____

Patient Employer: _____ Phone #: _____

Employer's Address: _____
Street City State Zip Code

Occupation: _____ Spouse's/Partner's Name: _____

How did you hear about us? _____

Insurance Information

Was this injury work related? _____Yes _____No Auto Accident? _____Yes _____No

Do you have health insurance? _____Yes _____No Insurance Company: _____

Informed Consent

I hereby authorize the doctor to provide any and all form of treatment, evaluation, radiographs, and therapy that may be indicated in connection with the care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as (s)he sees fit. I also understand that prior to treatment, full explanation of the procedure(s) involve will be given by the doctor. I agree to pay for all services rendered in this office.

Signature: _____ Date: _____/_____/_____

Relationship to Patient: _____

360 Route 101 • Unit #7 • Bedford, NH 03110 • *p* 603-647-0600 • *f* 603-647-0633

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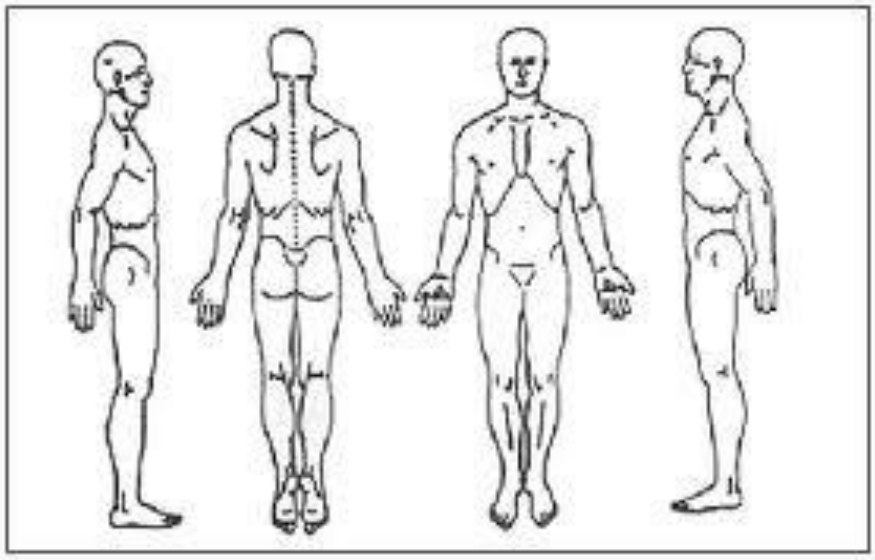
Symptom Survey

Patient's Name: _____ Date: _____/_____/_____

1. **Pain Diagram**: ***Please mark on the diagram the type of pain and the location:***



What is the type of pain you are currently experiencing?

Please circle all that apply:

Achy

Numbness

Pins & Needles

Burning

Stabbing

What is the intensity of your pain?

Please circle one:

Slight

Minimal

Moderate

Severe

2. **Visual Current Pain Severity Scale:**

*Please place a vertical mark on the grey line below that corresponds to your **current** pain:*

No Pain Worst Pain Ever

3. **Symptom Questionnaire**

When did the pain first begin? _____

Is this current pain a flare-up? _____

What caused your pain? _____

What makes the pain better? _____

What makes the pain worse? _____

How often do you have your pain? _____

For how long does your pain last? _____

Any prior injuries or accidents to the area of pain? _____

_____

Have you seen another healthcare practitioner for the pain/condition? _____

If so, who? _____

Have you had any x-rays or other imaging or blood tests within the past two years? _____ Yes _____ No

If yes, please bring or request these (or at least the reports) to your next appointment.

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Past Medical History

Patient's Name: _____ Date: _____/_____/_____

Have you ever been treated by a chiropractor? _____ Yes _____ No

Were you treated for the same condition as you have today? _____ Yes _____ No

Clinic or Doctor's Name: _____ Clinic phone #: _____

Are you taking any of the following medications? _____ Nerve Pills _____ Pain Killers (including aspirin)

_____ Muscle Relaxers _____ Blood Thinners _____ Tranquilizers _____Insulin _____ Other(Please List)

_____

Do you or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect
Y N Mitral Valve Prolapse	**Y N** Artificial Valves	**Y N** Alcohol/Drug Abuse	**Y N** Venereal Disease
Y N Hepatitis	**Y N** Anemia/Diabetes	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Glaucoma	**Y N** Kidney Problems	**Y N** High/Low Blood Pressure
Y N Psychiatric Problems	**Y N** Rheumatic Fever	**Y N** Severe/Freq. Headaches	**Y N** Tuberculosis
Y N Ulcers/Colitis	**Y N** Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Emphysema/Asthma
Y N Arthritis	**Y N** Difficulty Breathing	**Y N** Chemotherapy	**Y N** Chronic Low Back Pain
Y N Artificial Joints	**Y N** Artificial Implants		

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

_____

List any past serious accidents with dates: _____

_____

Please list any allergies: _____

Please provide your family health history: _____

_____

Do you take supplements/vitamins? _____ Yes _____ No Please list: _____

Do you smoke? _____ Yes _____ No How many Packs/day? _____ For how long? _____

Are you dieting? _____ Yes _____ No Since how long? _____

For Women: Are you taking birth control? _____ Yes _____ No Are you nursing? _____Yes _____ No

Are you pregnant? _____ Yes _____ No If so, how many weeks? _____

I guarantee that this form was filled out to the best of my knowledge and understand that is my responsibility to inform this office of any changes to the information that I provided:

Signature: _____ Date: _____/_____/_____

_____Adult Patient _____Parent or Guardian _____Spouse

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Privacy Policy

This summary discloses how health information about you may be used.

Northeast Lifestyle Medicine, LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Northeast Lifestyle Medicine, LLC will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Northeast Lifestyle Medicine, LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Northeast Lifestyle Medicine, LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

Northeast Lifestyle Medicine, LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms and of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Signature: _____ Date: _____/_____/_____

_____Adult Patient _____Parent or Guardian _____Spouse