WEISS CHIROPRACTIC

DR. KEITH A. WEISS

133 LOUDON RD. CONCORD NH 03301
WWW.WEISSCHIRO.COM 603 224 1846

MEDICAL HISTORY FORM

PLEASE PRINT

Name:_____Date:_____

MAIN PROBLEM

What pain brings you to the office?_____
What caused this pain?_____
When did this pain start?_____How long does this pain last?_____
How bad is this pain? (Circle the one that applies)

Mild Mild to Moderate Moderate Moderate to Severe Severe

Please rate this pain on a scale of 0-10 (10 being severe) **0 1 2 3 4 5 6 7 8 9 10**
Circle the word or words that best describe the pain.

Cramping	**Dull**	**Shooting**	**Stiff**	**Stinging**
Aching	**Sharp**	**Stabbing**	**Nagging**	**Dead**
Burning	**Numbing**	**Throbbing**	**Tingling**	

How often does the pain occur? (Circle the one that applies)

Constantly (76%-100%) Frequently (51%-75%) Occasionally (26%-50%)
Intermittently (0%-25%)

Does this pain travel to any other area?_____
What makes this pain better?_____
What makes this pain worse?_____
What else have you done to treat this pain?_____

ADDITIONAL PROBLEM(S)

What other pain do you have?_____
What caused this pain?_____
How bad is this pain? (Circle the one that applies)

Mild Mild to Moderate Moderate Moderate to Severe Severe

Please rate this pain on a scale of 0-10 (10 being severe) **0 1 2 3 4 5 6 7 8 9 10**
Circle the word or words that best describe the pain.

Cramping	**Dull**	**Shooting**	**Stiff**	**Stinging**
Aching	**Sharp**	**Stabbing**	**Nagging**	**Dead**
Burning	**Numbing**	**Throbbing**	**Tingling**	

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What else have you done to treat this pain? _____

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FAMILY HISTORY

Please tell us about the health of your parents. Circle everything that applies. If someone is deceased, please circle and write in the cause.

Deceased M/F cause:_____

Heart disease M/F Stroke M/F Cancer Diabetes M/F Rheumatoid Arthritis M/F

Multiple Sclerosis M/F Lung Disease M/F Bone Disease M/F

PAST AND SOCIAL HISTORY

Are you employed Y N Where_____

How is your general health?_____

Do you drink alcohol Y N Use tobacco Y N Use recreational drugs Y N

Have you had any illnesses? (This includes, but is not limited to: heart disease, high cholesterol, high blood pressure, diabetes, cancer, etc)

_____

_____

_____

Have you had any injuries? (car accidents, broken bones, etc)

_____

_____

_____

Have you been hospitalized? (Explain)

_____

_____

_____

Have you had any surgeries? (Explain)

_____

_____

_____

List any medications that you are taking and WHY (continue on back if necessary).

_____

_____

_____

_____

_____

I certify that the information that the information that I have given here is true and accurate to the best of my knowledge.

Patient Signature_____Date_____

Print_____

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PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name _____ First Name _____Middle _____
Gender M F Date of Birth ____ / ____ / ____ Age _____
Home Address _____
City _____State _____ Zip_____
Home Phone #_____ cell phone #_____Email_____
Work Phone #_____ Preferred method of contact_____
Employer Name _____Occupation _____
May we contact you at work? Y/N
Employer Address _____
City _____State _____Zip_____
SPOUSE /PARTNER OR GUARDIAN
Last Name _____ First Name _____

Referred by_____

MY PRIVACY

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ _____
Signature of patient or person acting on patient's behalf Date

*****To save you time and paperwork, please allow us to copy your insurance card**

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X _____ _____
Signature of patient or responsible party Date

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

X _____ _____
Signature of patient or responsible party Date

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_____
Please print name above

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc.on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

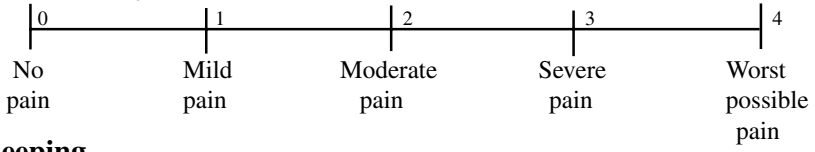
x_____ _____
Witness to Patient's Signature Date

Functional Rating Index

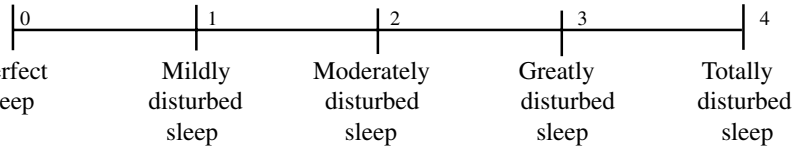
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

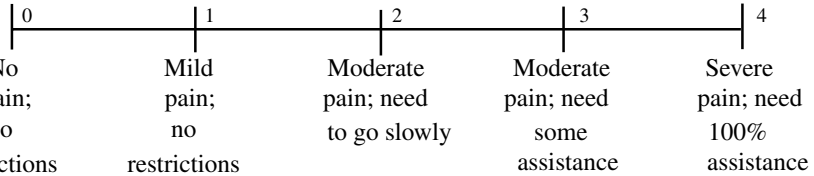
1. Pain Intensity



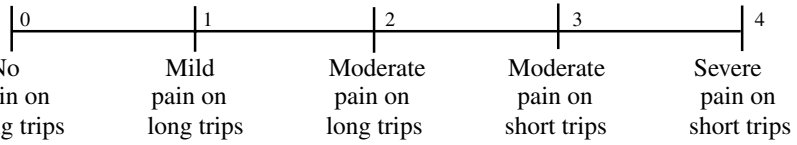
2. Sleeping



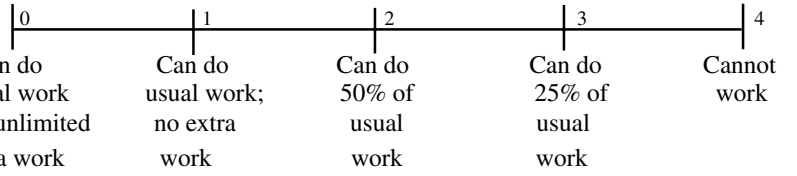
3. Personal Care (washing, dressing, etc.)



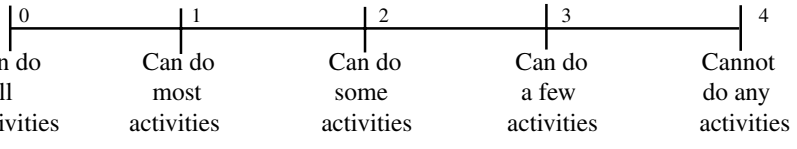
4. Travel (driving, etc.)



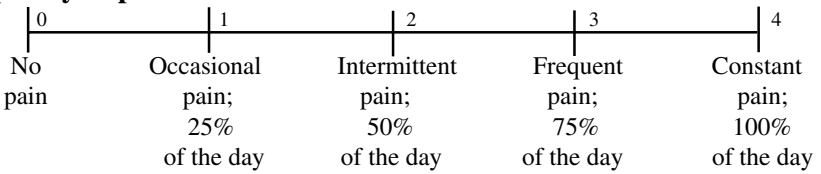
5. Work



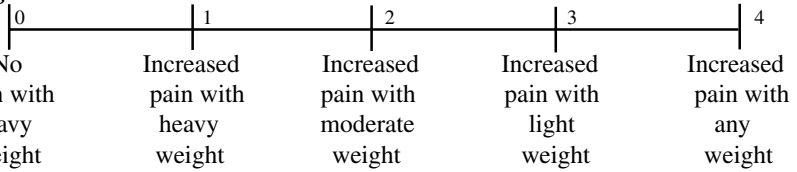
6. Recreation



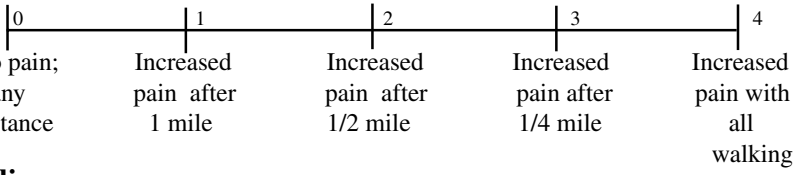
7. Frequency of pain



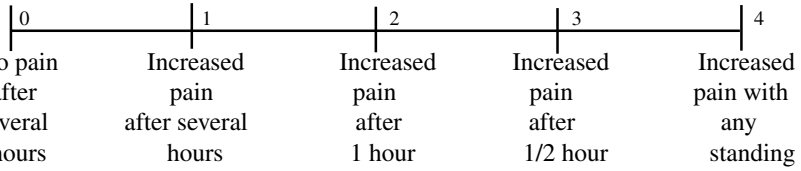
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date