JAFFREY CHIROPRACTIC
JOSHUA J. HIRSCHD.C
603-532-5629
FX 603-652-3368
45 KNIGHT STREET SUITE 8
JAFFREY, NH 03452

New Patient Intake Form

Title: (Circle one) Mr. Mrs. Ms. Miss Dr. Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth _____/_____/_____ **Sex:** Male Female

Social Security Number: _____-_____-_____ **Marital Status:** Single Married Other

Employment Status: Employed Unemployed FT Student PT Student Other_____

Employer Data _____

Employer _____

Your Occupation _____

Spouse Data _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Spouse Date of Birth _____/_____/_____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

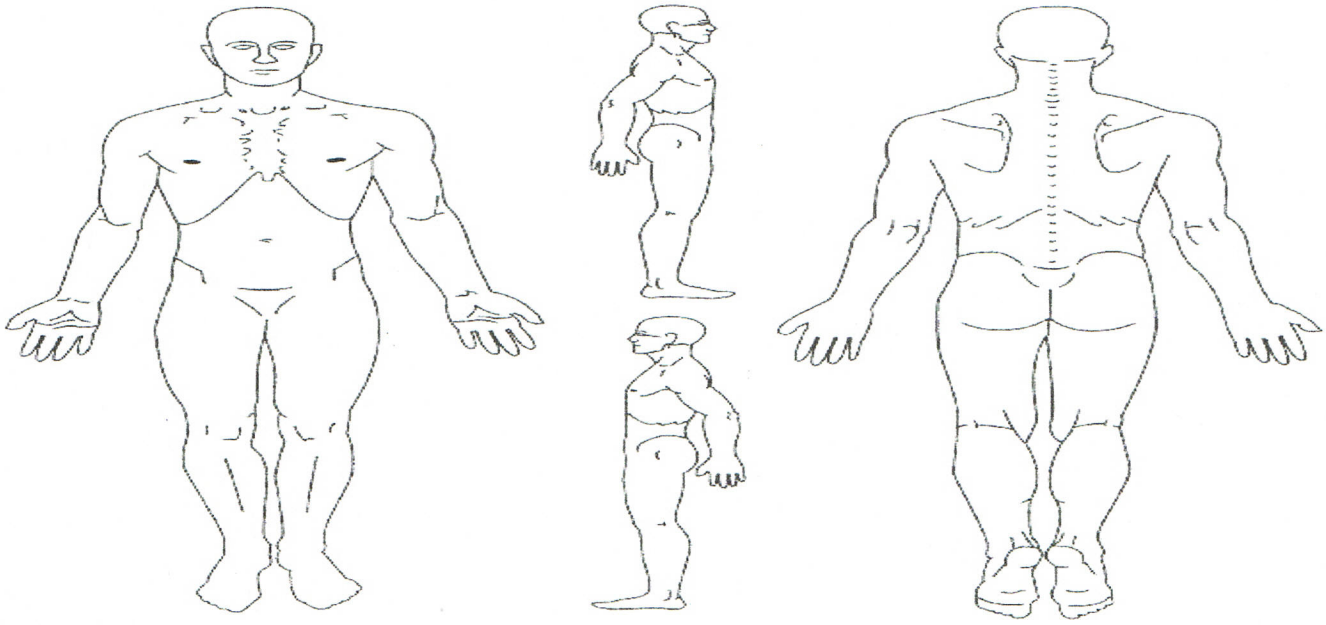
How did you hear about our office? _____

Dr Hirsch is a participating provider for, **MEDICARE, Harvard Pilgrim, and Workman's Comp cases**, and will submit claims on your behalf. Your signature below authorizes Joshua J. Hirsch D.C. (Jaffrey Chiropractic Health Center) to release any health care records that may be required for you to obtain reimbursement from your insurance carrier or HSA only. It also authorizes this office to communicate with any and all of your health care providers for the purpose of continuity of your care and or record requests. I understand that I am fully responsible for payment of my health care in this office, and that my payment is expected at the time of the service. I also certify that I have answered the questions on this form truthfully and to the best of my Knowledge.

Patient Signature_____Date_____

Patient Name_____ **Date**_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:

Last 24 hours:	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain
Past week:	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain

When did your symptoms begin? _____

Are your symptoms a result of: Motor Vehicle Accident Work related Accident Other_____

How often do you experience your symptoms?
Constantly Frequently Occasionally Intermittently

What describes the nature of your symptoms?

Sharp	Ache	Numb	Shooting
Burning	Tingling	Throbbing	Other _____

In as much detail as possible please describe your complaints, including how, and when they began, and what makes them worse, or better.

Patient Signature_____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Other _____

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper
Other _____			

Doctor's Signature _____

Patient Name _____ Date _____

Name:_____ **Date**_____

Review of Body Systems (please check)
__ Lethargy/ weakness
__ Recurring Fevers
__ Recent weight loss/gain
__ Dizziness
__ Chills
__ other

Respiratory
__ Persistent cough
__ Spitting up blood
__Asthma
__ Shortness of breath
__Sleep Apnea
__ Emphysema
__ Snoring issues
__ Tuberculosis
__ Pneumonia
__Hay fever

Eyes/ears/nose/throat
__ Headaches
__ Eye/vision problems
__ Glasses/contacts
__ nose Bleeds
__ Eye surgery
__ Cataracts
__ Glaucoma
__ Sore throats
__ Hoarseness
__ Swollen Glands
__ Sinus Congestion
__ Ear/hearing problems
__ Dental Problems
__ Gum Problems
__ TMJ problems
__ Other

Skin/Hair
__Rashes
__Flushing
__Acne
__Eczema
__Psoriasis
__Skin Cancer
__Blood in stool
__Bruising
__Bleeding gums
__Other

Heart / Chest
__ Chest Pain
__ Heart Attack
__ Shortness of Breath
__ Palpitations
__ Swelling in feet/ hands
__ High Blood pressure
__ High Cholesterol
__ Heart Murmur
__ Blood Clots
__ Pacemaker
__ Mitral valve prolapse
__ Leg pain when walking
__ Heart defects
__ Varicose Veins
__ Dizziness
__ Coronary artery disease

Gastrointestinal
__ Loss of appetite
__ Nausea/Vomiting
__ Diarrhea
__ Constipation
__Abdominal Pain
__ Ulcers
__ Cramping
__ Heartburn
__ Hemorrhoids
__ Hepatitis
__ Cirrhosis
__ Difficulty swallowing
__ Jaundice
__ Liver disease
__ Gallbladder problems
__ Pancreatitis
__ Black/Bloody Stool
__ Colon cancer
__ Food allergies
__ IBS
__ Reflux
__ Colitis
__ Other

Neurological
__ Frequent headaches
__ Migraines
__ Dizziness
__ Fainting
__ Memory Loss
__ Poor balance
__ Numbness/tingling
__ Epilepsy/Seizures
__ Stroke
__ Tremors
__ Head injury
__ Anxiety/panic attacks
__ Depression
__ Poor Sleep
__ Weak Muscles
__ Loss of smell/taste
__ Loss of vision
__ Poor concentration
__ Other

Musculoskeletal
__ Arthritis
__ Joint pain/ swelling
__ Neck pain
__ Back pain
__ Trauma
__ Osteoporosis
__ Scoliosis
__ Muscle cramps
__ Broken bones
__ Plates/Screws
__ Hip problems
__ Joint replacements
__ Knee problems
__ Foot/Ankle pain
__ Poor posture
__ Gout
__ Other

Blood/Lymph
__ Anemia
__ Bleeding
__ Bruising
__ Blood clots
__ Leukemia
__ Lymphoma
__ HIV/AIDS
__ Sickle cell anemia

Allergies
__Seasonal
__ Medication
__ Food
__ Other

Psychiatric
__ Alzheimer's
__ Memory loss/confusion
__depression/anxiety
__ Suicidal thoughts
__ Chemical dependency

Endocrine
__ Diabetes
__ Thyroid problems
__Sweating
__ Heat/cold intolerance
__ Weight loss/ gain
__ Excessive thirst
__ Change in appetite
__ Hyperthyroid
__ Low testosterone
__ Steroid treatments

Urinary
__ frequent urination
__ Poor urine control
__Blood in urine
__ Kidney Stones
__ Urinary infections
__ Other

Male
__poor urine control
__ Loss of libido
__ Erectile dysfunction
__ STDs
__ Prostate problems/ cancer

Female
__Pregnant
__ Menopause
__ Breast pain/lumps
__ Breast cancer
__ Breast Implants
__ Loss of libido
__ Irregular cycles
__ STDs

List Medications Taken

Signature_____

JAFFREY CHIROPRACTIC HEALTH CENTER

Disclosure & Consent for Chiropractic Adjustments and Care

To the Patient: *You have a right to be informed about your condition and the recommended chiropractic adjustments and the other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks hazards inherent to the procedure.*

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy on me or the patient named below whom I am legally responsible for by Joshua J. Hirsch, D.C., or those working at the office who now, or in the future treat me while employed by, working or associated with, or serving as a backup for Dr. Hirsch.

I have had the opportunity to discuss with the doctor, my diagnosis, the nature and purpose of undergoing chiropractic care and other procedures.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and possible increase symptoms or pain. 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 on the facts known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Date_____

To be completed by patient:

Print Name

_____

Signature of Patient

_____

To be completed by the patient representative, if the patient is a minor or physically or legally impaired.

Patient Name_____

Your Name _____

Relationship To Patient: _____

Signature of Patient Representative

_____

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

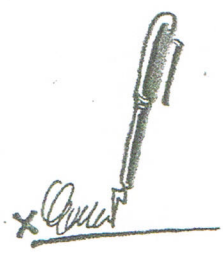
Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!



_____

Patient Signature

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

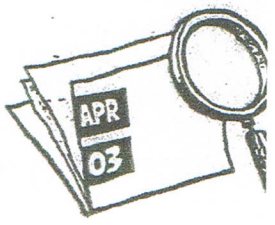
Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may requ that we only communicate your health information privately with no other family members pr or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information



You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the term of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concer you may have regarding the privacy of your information. Please let us know of your concerns