



# Hollis Family Chiropractic Center, PLLC

## New Patient Intake Form

4 Market Place, PO Box 1585, Hollis, NH 03049  
p: 603.465.2235 f: 603.465.2236

### ***About You***

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: [ ] M [ ] F  
Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other: \_\_\_\_\_  
Names and Ages of Children: \_\_\_\_\_  
Insurance: [ ] Work Comp [ ] Auto [ ] Medicare [ ] Private: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Who may we thank for referring you to us? \_\_\_\_\_  
How would you like appointment reminders sent: [ ] email [ ] text: cell provider \_\_\_\_\_

### ***Your Health Profile***

*As a family chiropractic office, we focus on your ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you the opportunity of improved health and wellness potential.*

Describe the issues that brought you to our office: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have no symptoms or complaints and are here for **wellness services**, please check

What are your health goals?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your current condition the result of: [ ] an auto accident? [ ] a work related injury?  
Date of injury? \_\_\_\_\_

Have you had previous chiropractic care? [ ] Y [ ] N

If yes, what was the doctor's name? \_\_\_\_\_

What was the approximate date of your last visit? \_\_\_\_\_

Please describe below, in the following 2 sections, your primary and any additional reasons for seeking care in our office:

**Primary complaint** (List one only): \_\_\_\_\_

When did you first experience this problem? \_\_\_\_\_

If your complaint is the result of an injury, describe what happened? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How often do you experience this problem?  1-2x/week  3-4x/week  5-6 x/week  daily  
 other: \_\_\_\_\_

On a scale of 0-10 with 10 representing the most severe pain imaginable, rate the average severity of your pain.  
0 1 2 3 4 5 6 7 8 9 10

What is the least intense the symptom has been on a scale of 0-10?  
0 1 2 3 4 5 6 7 8 9 10

What is the most intense the symptom has been on a scale of 0-10?  
0 1 2 3 4 5 6 7 8 9 10

Have you experienced these symptoms before?  Y  N

When? \_\_\_\_\_

How would you describe the symptoms (i.e. burning, stabbing aching, sharp, etc.)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the location of the pain: \_\_\_\_\_  
\_\_\_\_\_

Does this problem cause pain to travel to any other area?  Y  N If yes, where? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this problem getting:  worse?  better?  staying the same?

What seems to aggravate this problem? \_\_\_\_\_  
\_\_\_\_\_

What have you tried to relieve this problem (i.e. interventions, treatments, medications, surgery)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you seen any other doctors for this problem?  Y  N If yes, who? \_\_\_\_\_  
\_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the treatment? \_\_\_\_\_

**Additional Complaints** – (List anything else you'd like to discuss with the doctor):

When did you first experience this problem? \_\_\_\_\_

How did this problem first begin? \_\_\_\_\_

How often do you experience this problem? \_\_\_\_\_

When did these symptoms begin? \_\_\_\_\_

How would you describe the symptoms? \_\_\_\_\_

Please describe the location of the pain: \_\_\_\_\_

Is this problem getting:     worse?     better?     staying the same?

What seems to aggravate this problem? \_\_\_\_\_

What have you tried to relieve this problem? \_\_\_\_\_

Have you seen anyone for this problem? If yes, who? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How effective was the treatment? \_\_\_\_\_

**Lifestyle/Social History**

What physical activities do you perform at work? (example: prolonged sitting, computer/desk, lifting, prolonged standing, etc...) \_\_\_\_\_

How many hours per week do you work? \_\_\_\_\_

What recreational activities/hobbies do you regularly engage in? \_\_\_\_\_

Do you smoke cigarettes?     Y     N    If yes, how much? \_\_\_\_\_

Do you drink alcohol?     Y     N    If yes, how much? \_\_\_\_\_

Do you drink coffee?     Y     N    If yes, how much? \_\_\_\_\_

Do you drink tea?     Y     N    If yes, how much? \_\_\_\_\_

How regularly do you exercise?     daily     \_\_\_\_\_x/week     occasionally     never

What kind of exercise do you do? \_\_\_\_\_

How many hours of sleep do you get on average? \_\_\_\_\_

On a scale of 0-10 please rate your stress level (0=none and 10=extreme):

Occupational \_\_\_\_\_

Personal \_\_\_\_\_

## **Medical History**

Please check any of the following illnesses you have had:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lyme	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Thyroid Disorder

### **Surgeries:**

Date	Type and reason for surgery
_____	_____
_____	_____
_____	_____
_____	_____

### **Accidents or Injuries:**

Date	Details
_____	_____
_____	_____
_____	_____
_____	_____

### **Medications & Supplements**

Reason for taking

_____	_____
_____	_____
_____	_____
_____	_____

### **Allergies**

\_\_\_\_\_  
\_\_\_\_\_

## **Women Only**

*Pregnancies and outcomes:*

Date of pregnancy	Outcome
_____	_____
_____	_____
_____	_____
_____	_____

Are you pregnant?    Yes    No    Not sure

# Medical History

Please check any of the following you have experienced in the **past 6 months**:

## MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Headaches
- Joint Pain/Stiffness
- Walking Problems
- Difficult Chewing/Clicking Jaw
- General Stiffness

## NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress
- Hearing Difficulty

## GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating after Meals
- Heartburn
- Black/Bloody Stools
- Colitis

## GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

## CARDIO-VASCULAR-RESPIRATORY

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

## EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Stuffed Nose

## MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems:

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## GENERAL

- Fatigue
- Allergies
- Headaches
- Fever

Please give us any other health information you may feel would be helpful: \_\_\_\_\_

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## ***Authorizations and Releases***

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### ***Authorization and Agreement for Payment of Services Rendered:***

I authorize Hollis Family Chiropractic Center, PLLC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claims for reimbursement of charges incurred by me.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account upon receipt.

***I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.*** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

### ***Informed Consent for Examination and Treatment***

This document explains some potential risks associated with chiropractic care. Please read this information carefully, and let our staff know if you have questions.

The doctor and staff of Hollis Family Chiropractic Center, PLLC will do everything to assist you with your health, or your condition. Please be aware that, as with all healthcare systems, we cannot guarantee a cure or resolution of your problem. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. Nor do we offer advice regarding a previous diagnosis or treatment prescribed by others.

While Chiropractic care is remarkably safe, there are some risks associated with it, and we feel you need to be fully informed about these risks before consenting to treatment.

**Soreness** – Chiropractic adjustments and associated therapies may sometimes cause post-treatment soreness. While soreness is usually mild and temporary, please advise your doctor if you experience this.

**Soft Tissue Injury** – Rarely, Chiropractic treatment may aggravate a disk injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

**Rib Injury** – Adjustments to the mid back, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk for fracture. Treatment is performed carefully to minimize such risk.

**Stroke** – Stroke is the most serious complication of Chiropractic care, but fortunately its occurrence is extremely rare. The most recent studies estimate that the incidence of this type of stroke is one in five million neck adjustments.

**Other Complications** – There are occasionally other types of side effects associated with Chiropractic care. While these are rare, they should be reported to your doctor promptly.

We will make every reasonable effort during examination to screen for potential risks. Please be aware that if you have a condition that would otherwise not come to our attention, it is your responsibility to inform the doctor.

I, the undersigned, agree that I have read, or have had read to me, and understand the information stated above. I hereby authorize the doctor and staff of Hollis Family Chiropractic Center, PLLC to perform examination procedures and administer treatment to me, or to the person listed below for whom I serve as legal guardian. I understand that all procedures and treatment will be explained to me before they are performed, and that I have the right to refuse any such procedures.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or guardian, if patient under age 18)