Amoskeag Chiropractic Health Center
55 Amoskeag St. Manchester, NH 03102
(603) 624-8000 amoskeagchiro@gmail.com www.nhchiropractors.com

Amoskeag Chiropractic Health Questionnaire

Name_____ **Home Phone** _____

Address_____ **Cell Phone/Pager**_____

City,State,Zip _____ **Birthdate**_____

Male/Female Age_____ **SS#**_____ **Email**_____

Occupation_____ **Employer**_____ **Employer's Phone#**_____

Employer's Address_____

Marital Status: M W D S Spouse Name_____ **No# of Children**_____

Name of Children_____

1. Many patients are referred to our office by a family member or friend. What or who made you decide to visit our office?

_____

2. Science tells us your spine should be cared for regularly. How often do you get adjusted by a chiropractor?
Frequently/only when you hurt/1 x monthly/never

3. When was your last complete spinal examination including x-rays?_____ **□ Never**

4. Do you know if you have a spinal curvature, spinal arthritis, or inherited spinal problem? □ Yes □ No

5. Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? □ Yes □ No

6. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? □ Yes □ No

7. Poor posture leads to poor health and early death. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. Stress will cause you to accelerate spinal damage. Rate your stress level over the last 3 months.
Calm/Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

9. Please circle or list any health symptoms or health complaints you are experiencing.

Neck pain L/R	**Arm pain/Numbness L/R**	**Asthma**	**Thyroid**
Back Pain L/R	**Leg pain L/R**	**Cancer**	**Allergies:**_____
Mid-back pain L/R	**Headaches/Migraines**	**Constipation**	_____
Lower-back pain L/R	**Diabetes I/II**	**Menstrual pain**	_____

10. Prescription medications cause various side effects hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (use back if necessary)
1._____ **2.**_____ **3.**_____

11. Please list any surgeries you have had. _____

12. Daily trauma, auto accident(s), and work injuries can cause serious spinal problems.
When was your most recent injury at home?_____ **Car accident?**_____ **Slip or fall?**_____

13. Spinal health is vitally important to ensure a healthy pregnancy. Is there a chance you are pregnant? □ Yes□ No

14. Do you smoke? □ Yes □ No

15. Improper sleeping positions can cause spinal damage, what sleeping position do you sleep in: □ Back □ Stomach □ R Side □ L Side

16. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 6x @wk **17. Are you ? □ Right Handed □ Left Handed**

18. Please list vitamins/supplements you take:_____

19. If the doctor identifies your spine to be misaligned, are you committed to follow the recommendations to correct your problem completely?
□ Yes □ No

The above information is true and accurate to the best of my knowledge.

Patient Signature (Parent/Guardian):_____ **Date:**_____

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Amoskeag CHIRO-PRACTIC INC.

Patient Name: _____File:_____

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Amoskeag Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

Note: Our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Edward Rusher.

I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient, or Parent/Guardian of Patient) Date

Release of Medical Records:

I give my permission for Dr. Rusher to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition

_____

Signature (Patient, or Parent/Guardian of Patient) Date

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name **Signature** **Date**

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____

Signature **Date**

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