Amoskeag Chiropractic INC.
55 Amoskeag Street, Manchester, NH 03102
(603) 624-8000 www.nhchiropractors.com

Amoskeag Chiropractic Health Questionnaire

Name_____ Home Phone_____

Address_____ Cell Phone_____

City, State, Zip_____ Birth date_____

Male / Female Age_____ SS#_____ Email_____

Occupation_____ Employer_____ Employer's Phone_____

Marital Status: M W D S Spouse Name_____ Number of Children_____

Name of Children_____

1. Many of our patients are referred to our office by a family member or friend. Whom may we thank for referring you?_____

Why is This Form Important? As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first: to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you child has no symptoms or complaints, and is here for wellness services, please check this box ☐; others need to briefly describe the chief area of complaint, including the effect it has on the child: _____

If he/she is experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and Goes ☐ Travels ☐ Constant

Since the problem started, is it: ☐ About the same ☐ Getting Better ☐ Getting worse What makes it worse?_____

It interferes with: ☐ School ☐ Walking ☐ Sleep ☐ Sitting ☐ Hobbies ☐ Other:_____

Other doctors seen for this problem: ☐ Chiropractor_____ ☐ Medical Doctor_____ ☐ Other_____

List medications the child is taking or surgeries the child has had:_____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

PREGNANCY

Where there any complications to the pregnancy?_____

Was Mom on any medications, prescription or over-the-counter? ☐ Yes ☐ No If yes, explain:_____

Did Mom or Dad smoke during pregnancy? ☐ Yes ☐ No Who?_____

Was the baby ever in the Breech position? ☐ Yes ☐ No How many ultrasounds were performed?_____

BIRTH AND DELIVERY

Where was the baby born? ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other:_____

Was the delivery: ☐ Vaginal ☐ C-section Were any devices used? ☐ Forceps ☐ Vacuum

How long was the labor?_____ How long was the delivery?_____

Was oxytocin / pitocin used? ☐Yes ☐No Was an epidural administered? ☐Yes ☐ No

INFANCY

Was the infant vaccinated? ☐Yes ☐No Was there a vaccine related reaction? ☐Yes ☐No

Was there any prolonged use of medicines or an inhaler? ☐Yes ☐No If yes, which?_____

Did the infant suffer any traumas such as a serious fall(s) or car accident(s)? ☐Yes ☐No

Has the infant been under regular chiropractic care? ☐Yes ☐No

CHILDHOOD YEARS

Did the child have any childhood illnesses?	☐Yes	☐No	If yes, explain:_____
Does the child play youth sports?	☐Yes	☐No	Which sport?_____
Has the child had any surgery?	☐Yes	☐No	If yes, explain:_____
Has the child fallen from a height over 3 feet?	☐Yes	☐No	If yes, explain:_____
Was the child involved in any car accidents?	☐Yes	☐No	If yes, explain:_____
Has there been any prolonged use of meds?	☐Yes	☐No	If yes, explain:_____
Has the child suffered emotional traumas?	☐Yes	☐No	If yes, explain:_____

Please give us any other health information you feel would be helpful:_____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature:_____Date: _____

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

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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