GRANITE CHIROPRACTIC

Date of Exam

_____/_____/_____

New Patient Questionnaire

Please fill out this form to the best of your ability. The information that you provide will help us to evaluate your condition.

Patient Information

Legal Name: _____, _____

Last First

Preferred Name: _____ Sex: □ Male □ Female

(If different than legal)

Birth Date: _____ / _____ / _____ Height: _____ ft _____ in Weight: _____ lbs

Address: _____

Street Apartment #

_____

City State Zip Code

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Primary Care Physician: _____ Phone: _____

HAVE YOU SEEN A CHIROPRACTOR BEFORE? □ Yes □ No

HOW DID YOU HEAR ABOUT US: _____

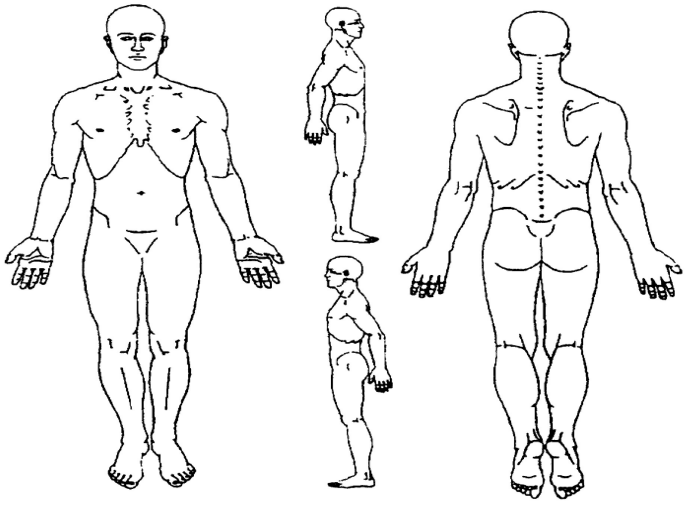
Consent for Treatment

Assignment & Release *- By signing below, I authorize Granite Family Chiropractic and Nutrition to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Granite Family Chiropractic and Nutrition PC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*
By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

Granite Chiropractic PC
333 Elm St, Suite 120, Dedham, MA 02026
T: 781.467.0088 F: 781.467.0098

Please mark the location of your pain with an X on the diagram below.



On a scale of 1 to 10, how intense are your symptoms? (Please circle a number)

Very Mild 1 2 3 4 5 6 7 8 9 10 Unbearable

1. Please state your major complaint/purpose for this appointment: _____

_____

2. Describe your pain: ☐Ache ☐Sharp ☐Shooting ☐Stabbing ☐Dull ☐Deep ☐Numbness☐Sore ☐Other

3. When did this problem begin? _____

4. What caused the pain to begin? _____

5. Is this problem accident-related? ☐Yes ☐No If so, what type of accident? _____

6. Who else have you consulted for this problem?

_____

Name of Practitioner Specialty

7. Have there been any recent changes in your weight? ☐Yes ☐No

If so, explain _____

8. Have you noticed any changes in bowel/bladder function? ☐Yes ☐No

If so, explain _____

9. Are your symptoms? ☐Getting better ☐Staying the same ☐Getting worse

10. Date of last complete physical: _____ / _____ / _____

11. Do you smoke? ☐Yes ☐No _____packs per day How many years have you been smoking? _____

12. Do you drink alcoholic beverages? ☐Yes ☐No _____drinks per week

13. Are you pregnant? ☐Yes ☐No ☐NA If so, how many weeks? _____

Are you currently breastfeeding? ☐Yes ☐No ☐NA Date of last menstrual period: _____ / _____ / _____

Personal History

Please check any of the following disorders that you have, or have had in the past:

☐Allergies	☐Chronic Diarrhea	☐Heart Disease	☐Palpitations	☐Stroke
☐Anemia	☐Constipation	☐Hemorrhoids	☐Pertussis	☐Thyroid Disorder
☐Arthritis	☐Diabetes	☐Hernia	☐Pneumonia	☐Tuberculosis
☐Blood in Urine	☐Difficulty Breathing	☐Hypertension	☐Polio	☐Ulcer
☐Bloody Stool	☐Difficulty Swallowing	☐Liver Disease	☐Renal Disease	☐Urinary Frequency
☐Cancer	☐Edema	☐Measles	☐Rheumatic Fever	☐Urinary Tract Infection
☐Chest Pain	☐Epilepsy	☐Mental Disorder	☐STD	☐Vertigo/Dizziness
☐Chicken Pox	☐Gallbladder Disease	☐Mumps	☐Sinusitis	☐Visual Dysfunction
☐Chronic Cough	☐Hearing Difficulty	☐Painful Urination	☐Small Pox	

Please explain any checked items: _____

Please describe any other conditions you have/had: _____

MEDICATIONS that you are currently taking: _____

VITAMINS/SUPPLEMENTS that you are currently taking: _____

Biological Family Medical History

Please check any condition below that your immediate, biological family members may suffer from, and write that family member's relation to you in the space provided.

☐Cancer_____ ☐Renal Disease _____

☐Diabetes_____ ☐Thyroid Disease _____

☐Heart Disease_____ ☐Tuberculosis _____

☐Hypertension _____ ☐Other Disease _____

Are your biological parents alive?

Biological Parent #1? □ Yes □ No If deceased, cause of death? _____

Biological Parent #2? □ Yes □ No If deceased, cause of death? _____

Patient's Signature_____ Doctor's Signature _____