Welcome!

The Pain Relief Center
163 Amherst Street
Nashua, NH 03064
603-886-4500
Nashuachiropractor.com

Welcome to our office. Please, take your time filling out this paperwork, ask any questions you may have, and do not fill out anything you do not know on this form. Thank you.

PATIENT INFORMATION

Date_____
SS#_____
Patient
Name_____
First Mid. Initial

_____
Last
Address_____
City_____
State_____ Zip_____
Sex: ☐ Male ☐ Female Age_____
Birthdate_____
☐ Married ☐ Divorced ☐ Single ☐ Separated
☐ Widowed ☐ Partnered for _____ years
Occupation_____
Employer/School_____
_____
Whom may we thank for referring you?
_____
Race:_____☐Decline to Disclose
Ethnicity:_____☐Decline to Disclose
Preferred Language:_____☐Decline to Disclose
Smoking Status (Circle): Former Smoker/ Smoke sometimes/ Smoke everyday/ Never Smoked ☐Decline

PHONE NUMBERS

Home Phone_____
Cell Phone_____
Work Phone_____
Email_____
Best phone to reach you at: ☐H ☐C ☐W
Emergency Contact_____
Emergency Contact phone_____
Relationship_____

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Y ☐ N
Date of Accident_____
Type of Accident: ☐ Auto ☐ Work ☐ Other

INSURANCE

Subscriber's Name _____
Birthdate_____
Relationship to Patient_____
Secondary Insurance_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Stephen Dohoney all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Patient, Parent, Guardian

_____
Printed Name

_____ _____
Date Relationship to Patient

PATIENT CONDITION

Reason for Visit_____
When did your symptoms appear?_____
Pain scale 1-10, with 10 being the worst pain_____
Is this condition getting progressively worse? ☐ Y ☐ N
Is this pain constant or does it come and go?
_____
How often do you have this pain?
_____
Does it interfere with your:
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Turning
☐ Bending ☐ Lying Down ☐ All of the above☐ Bending
☐ Lying Down ☐ All of the above