REDDY

----------FAMILY----------

CHIROPRACTIC

Dr. William Reddy
627 Central Ave.

Dover, NH 03820
603-749-3333

CONFIDENTIAL PATIENT DATA SHEET

The following information is needed in order to better serve you.
Please complete all questions. If you need help, please ask at the desk. Please print. Thank you

Name_____Home/Cell Phone_____Today's date_____.
Address_____City_____State_____Zip_____
Email Address_____
Age_____Birthdate_____Marital Status: S M W D Number of Children_____.
Your Employer_____Occupation_____Years on job_____.
Office Phone_____Insurance Co._____.
Name of Spouse or Parent/Guardian_____DOB_____.
Employed by_____Occupation_____Years on job_____.
Is this condition due to an accident? Yes No If so, date of accident_____.
Was this accident: Auto_____Work/on job_____At home_____Other_____.

Please circle one payment type: Cash Check Debit MC/VISA Discover AMEX

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are an arrangement between me and my insurance carrier and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature **X**_____Date_____.

Spouse/Guardian Signature **X**_____Date_____.

NOTICE TO OUR NEW PATIENTS: Full payment for services rendered is due at the end of today's visit.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photocopy of this agreement shall serve as the original.

Signature
X_____Date_____

CONFIDENTIAL PATIENT HEALTH HISTORY

Name_____Date_____.

Description of major complaint:_____

Check off all that apply and circle whether it's left or right sided:

	Sharp Pain	Dull Ache	Numbness	Pins and Needles	Burning Sensation	Stiffness
Head(L/R):	_____	_____	_____	_____	_____	_____
Neck(L/R):	_____	_____	_____	_____	_____	_____
Upper Back(L/R):	_____	_____	_____	_____	_____	_____
Mid Back(L/R):	_____	_____	_____	_____	_____	_____
Low Back(L/R):	_____	_____	_____	_____	_____	_____
Buttocks(L/R):	_____	_____	_____	_____	_____	_____
Hip(L/R):	_____	_____	_____	_____	_____	_____
Leg(L/R):	_____	_____	_____	_____	_____	_____
Knee(L/R):	_____	_____	_____	_____	_____	_____
Ankle(L/R):	_____	_____	_____	_____	_____	_____
Foot(L/R):	_____	_____	_____	_____	_____	_____
Hand(L/R):	_____	_____	_____	_____	_____	_____
Arm(L/R):	_____	_____	_____	_____	_____	_____

Other: _____

Date of most recent episode: _____

Dates of previous episodes: _____

Describe events or time of day, which seem to make this condition better: _____

_____

Describe events or time of day, which seem to make this condition worse: _____

_____

Have you experienced any other physical traumas? Yes No

If so, please describe:

Date/ Description: _____
Date/ Description: _____

What other doctors have you seen for your present condition?
Name(s):_____ Date: _____

Progress: Better_____ Worse_____ Same____.

Have you ever been hospitalized Yes No
When?_____Why?_____.

Have you ever had surgery Yes No
When?_____Why?_____.

Have you ever been to a Chiropractor? Yes No

Dr's name:_____.

PERSONAL HABITS:

Please list the name (s) of and purpose for any drug(s) you may be taking:
_____
_____
_____.

Rate your overall diet: Very good___ Good___ Fair___ Poor___ Very poor___.

Tobacco Yes No If yes, how much_____how often_____.

Alcohol Yes No If yes, how much_____how often_____.

Coffee Yes No If yes, how much_____how often_____.

Supplement Yes No If yes, how much_____how often_____.

Sleep: Average number of hours per night_____.

Quality of sleep: Good ____ Fair ____ Poor___.

Exercise: Yes No If yes, how much?_____ How often?_____.

What type of
exercise?_____

Date of last chiropractic adjustment:_____.

Current Stress Level:

Very High____ High____ Moderate____ Low____ Very Low___.

FEMALE HISTORY:

Date of last menstrual cycle:_____Regular_____ Irregular_____.

Birth control pills? Yes No Are you pregnant at this time? Yes No

I certify that the information given on the Confidential Patient forms are correct and complete to the best of my knowledge.

Signature **X**_____Date_____.