

# Boydén ▪ Family ▪ Chiropractic

40 S River Rd ▪ Bedford, NH 03110 ▪ (603) 626-1333

Date \_\_\_\_\_ Email \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Marital Status  Single  Married  Divorced  Widowed # Children \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Referred by \_\_\_\_\_

## Reason for visit

Reason for visit \_\_\_\_\_  
\_\_\_\_\_

Major complaint(s): \_\_\_\_\_  
\_\_\_\_\_

If you are experiencing pain, is it...

Sharp  Dull  Comes & Goes  Travels  Constant

How long has this been going on? \_\_\_\_\_

Is complaint(s):

Getting worse  No Change  Improving

Past treatment? \_\_\_\_\_

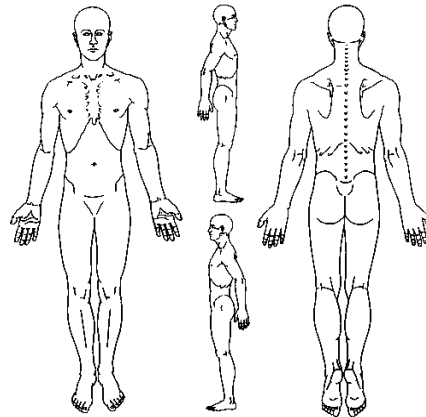
Did it help? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Use the letters below to indicate  
the type and location of your sensations  
right now on the drawing →

**A**=Ache      **B**=Burning      **N**=Numbness  
**P**=Pins & Needles      **S**=Stabbing      **O**=Other



## Surgical History

Please list any surgeries **and** recent or past traumas (including any accidents, falls, or injuries.)

<u>Date</u>	<u>Description</u>
_____	_____
_____	_____
_____	_____

**Health History**

**Current Medical conditions** \_\_\_\_\_

**Medications (include prescription and non-prescription drugs)** \_\_\_\_\_

**Date of last physical** \_\_\_\_\_ **Date of last x-rays** \_\_\_\_\_ **Type** \_\_\_\_\_  
**Name of your Medical Physician** \_\_\_\_\_

**How would you describe your: (circle best answer)**

Diet            *poor*    *good*    *excellent*  
Rest            *poor*    *good*    *excellent*  
Exercise        *poor*    *good*    *excellent*

**Habits:**

Smoke        *N*        *Y*\_\_ Pks/day  
Alcohol       *N*        *Y*\_\_ Amt/day  
Coffee        *N*        *Y*\_\_ Cps/day  
Stress Level (*1-10*)        \_\_\_\_\_

**Do you currently:**

**Yes No**

buy bottled water                       
belong to a health club                   
consume vitamins or supplements?

**Have you ever suffered from...**

- Dizziness                     Yes  No            If yes, how often? \_\_\_\_\_
- Backaches                     Yes  No            If yes, how often? \_\_\_\_\_
- Heart Trouble                 Yes  No            If yes, how often? \_\_\_\_\_
- Diabetes                       Yes  No            If yes, how often? \_\_\_\_\_
- High Blood Pressure         Yes  No            If yes, how often? \_\_\_\_\_
- Headaches                     Yes  No            If yes, how often? \_\_\_\_\_
- Asthma                         Yes  No            If yes, how often? \_\_\_\_\_
- Stomach Trouble               Yes  No            If yes, how often? \_\_\_\_\_
- Nervousness                  Yes  No            If yes, how often? \_\_\_\_\_
- Sinus Trouble                 Yes  No            If yes, how often? \_\_\_\_\_
- Neck pain                      Yes  No            If yes, how often? \_\_\_\_\_

**Authorization and Assignment**

*It is my understanding that if I become a patient in this office, I agree that payment is required at time of service unless other financial arrangements are made in advance. If financial arrangements are made, and Boyden Family Chiropractic allows me to charge services rendered to me, I authorize the release of any information concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement on any charges incurred by me as a result of services rendered by Boyden Family Chiropractic. I also authorize direct payment to Boyden Family Chiropractic. I also understand that I am responsible for payment of any charges incurred by me as a result of services rendered to me by Boyden Family Chiropractic. I understand that I am responsible for all co-pays and deductibles that apply to my Health Insurance plan and that I am financially responsible for all services not covered by my Health Insurance Plan.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_