WHITE MOUNTAIN
Chiropractic & Rehabilitation

1102 Route 119 Rindge, NH 03461
Tel: 603.899.5153 Fax: 603.899.5173

5 Dark Lane New Ipswich, NH 03071
Tel: 603.878.5387 Fax: 603.899.5173

140 Edmond Ave Portsmouth, NH 03801
Tel: 603.422.9220 Fax: 603.899.5173

PATIENT INFORMATION:

Name:			Date:	Sex: M F
Address:			Birthdate:	Age:
City:	State:	Zip:	Single [ ] Married [ ] Divorced [ ]	
Occupation:		Employer:		
Spouse's Name:		Birthdate:	Age:	
Occupation:				
How did you hear about White Mountain Chiro and Rehab?				

CONTACT INFORMATION:

Home Phone:	Cell Phone:	Work Phone:
Email (rehab exercises and appointment reminders):		
In case of emergency, contact:		Relationship:
Home Phone:	Cell Phone:	Work Phone:

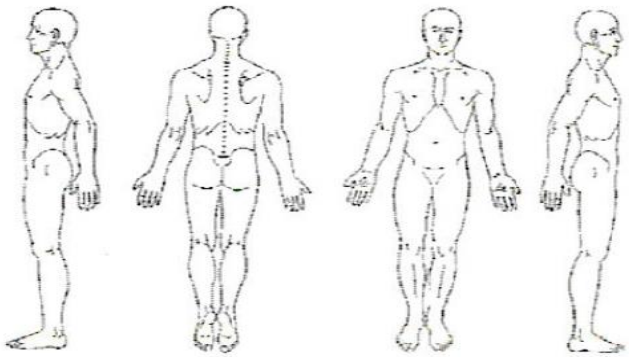
Primary Care Physician:_____Permission to correspond with PCP: **Y N**

CONDITION:

Chief Complaint / Reason for visit:_____

Please mark on the line below the intensity of your pain:

No Pain ---------- Unbearable



Please mark on the diagram areas of discomfort with the following key:

S = Sharp A = Ache
N = Numbness
B = Burning T = Tingling
► = Shooting O = Other

Date of onset:_____Describe how your symptoms began:_____

_____

On a scale of 1 to 10 [10 being the worst] where is your pain: at its best: _____/10 at its worst: _____/10

(please circle all that apply)

Type of pain: Sharp Dull Aching Stiffness Burning
Numbness Tingling Throbbing Shooting Spasms

Frequency: Constant Frequent Comes and goes Worse in Morning Worse in Evening

What IMPROVES your symptoms: Lying down Sitting Standing Walking
Exercise Inactivity Nothing

Other: _____

What WORSENS your symptoms: Lying down Sitting Standing Walking
Exercise Inactivity Nothing

Other: _____

Does your problem interfere with: Work Hobbies Daily Activity Sleep

Other: _____

Have you received treatment for your current condition? Y N If yes, by whom? _____

Expectation of today's visit: _____

HEALTH HISTORY: Please indicate if you have had any of the following

	Y	N		Y	N		Y	N		Y	N		Y	N
ABNORMAL WEIGHT GAIN			ABNORMAL WEIHGT LOSS			ALCOHOLISM			APPENDICITIS			ARTHRITIS		
ASTHMA			BALANCE PROBLEMS			CANCER			HEAD INJURY			CHICKEN POX		
DIABETES			DIZZINESS			FRACTURES			GOITER			GOUT		
HEART DISEASE / CONDITION			CAR ACCIDENT			HERNIA			HERNIATED DISC			HIGH CHOLESTEROL		
KIDNEY DISEASE			LIVER DISEASE			LOSS OF CONSCIOUSNESS			MIGRAINES			NIGHT SWEATS		
MULTIPLE SCLEROSIS			HIGH BLOOD PRESSURE			OSTEOPEROSIS			PACEMAKER			PARKINSON'S DISEASE		
PINCHED NERVE			PNEUMONIA			PROSTATE DISEASE			PROSTHESIS			PSORIASIS		
RHEUMETOID ARTHRITIS			STROKE			THYROID PROBLEMS			VISUAL DISTURBANCES			TUBERCULOSIS		
TUMORS			ULCERS			BOWEL/BLADDER DSYFUNCTION			BLOOD DISORDER / CLOTS			FIBROMYALGIA		
LONG TERM STEROID USE			LONG TERM ANTIBIOTICS			WEAKNESS IN ARMS/LEGS			ANXIETY / DEPRESSION			OTHER		

Exercise/Physical Activity: None Mild Moderate Heavy

Work: Sitting Standing Heavy Labor

Hospitalizations: _____

Falls: _____ **Car Accident:** _____

Patient Name _____ Patient Signature _____ Date _____

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INSURANCE AND TIME OF SERVICE PAYMENT

Our office is pleased to accept your insurance plan.The copay, deductible and any amount that is not paid by the insurance company are the patient's responsibility. The patient will be billed for any balance not paid by the insurance company within 90 days, unless other arrangements are made with White Mountain Chiropractic & Rehabilitation.

Services or therapies that may not be covered, specifically by **Medicare**, include but are not limited to:

New Patient Initial Exam/Re-exam
Physiotherapy (Heat, Cold, Electric Muscle Stimulation)
Therapy Extremity Chiropractic Adjustment
Rehabilitation Exercises
Soft Tissue
Taping

Estimated Time of Service cost for these **non-covered services/therapies may range from $5.00-$45.00**

TIME OF SERVICE (TOS) DISCOUNT

Whether your insurance covers chiropractic services or not, White Mountain Chiropractic & Rehabilitation offers a Time of Service (TOS) Discount to everyone. In order to qualify for this discounted payment option, all fees must be paid the same day the services are provided (at the discounted rate). If you would like to be reimbursed for the TOS amount by your insurance, it is your responsibility to submit the documentation.

ASSIGNMENT OF INSURANCE PROCEEDS

If you do have insurance, by agreeing to this assignment, we will direct your insurance company to make payments for your chiropractic, physiotherapy, physical rehabilitation or any other reimbursable treatment or evaluations you receive directly to White Mountain Chiropractic & Rehabilitation.

In exchange for services and supplies rendered, I do assign to White Mountain Chiropractic & Rehabilitation any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I am responsible for all charges to my account.

Patient Name _____ Patient Signature _____ Date _____

If Patient is a Minor,

Parent/Guardian Name _____ Relationship to Patient _____ Date _____

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INFORMED CONSENT FOR EXAMINATION, TREATMENT, & PRIVACY PRACTICES

I hereby request and consent to the performance of examination and treatment on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Dr. Colby B. Lamson, Dr. Rachel L. Morgan and/or other licensed doctors of chiropractic who now or in the future work at White Mountain Chiropractic & Rehabilitation or any other office or clinic. Treatment includes chiropractic manipulation/adjustments and other chiropractic procedures, including various modes of physiotherapy, soft-tissue therapy, rehabilitative therapy and/or referral for diagnostic tests as necessary,

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The Notice of Privacy Practices has been made available to me and I consent to the use or disclosure of my protected health information for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my care or to conduct health care operations of this office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information and my rights and duties of this office with respect to my protected health information

Patient Name	Patient Signature	Date

If Patient is a Minor,

Parent/Guardian Name	Relationship to Patient	Date