Congratulations On Your Journey To Routine Health

Lundgren Chiropractic – 603-432-1800

50 Nashua Road, Suite 101, Londonderry, NH 03053

PLEASE PRINT, COMPLETE & BRING THE COMPLETED FORM TO YOUR FIRST VISIT

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Case Of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contacts Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Did You Hear About Our Dr. Dave?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Explain Reason For Your Visit Today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate Your Pain



How Long Have You Been In Pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Your Pain Getting Worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Your Pain Constant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does Your Pain Come & Go?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does Your Pain Interfere With Your Life/Fun\_\_\_\_\_\_ Sleep\_\_\_\_\_\_ Daily Routine\_\_\_\_\_\_ Work\_\_\_\_\_\_ School\_\_\_\_\_

Are You In Pain When: Sitting\_\_\_\_\_\_\_\_ Standing\_\_\_\_\_\_\_\_ Walking\_\_\_\_\_\_\_\_ Bending

What Treatment, If any, Have You Received For This Condition?

Acupuncture\_\_\_\_\_\_\_\_ Chiropractic Care\_\_\_\_\_\_\_ Medication \_\_\_\_\_\_\_ Physical Therapy\_\_\_\_\_\_\_ Surgery\_\_\_\_\_\_\_

Other Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Doctor, Last Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Your Condition The Result Of A Fall\_\_\_\_\_\_\_\_\_\_ Automobile Accident\_\_\_\_\_\_\_\_\_ Work Related\_\_\_\_\_\_\_\_\_\_\_\_\_

If Yes, Has An Injury Report Been Filed\_\_\_\_\_\_\_\_\_

If An Attorney Has Been Retained: Attorney Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Of Last Physical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Of Last Spinal X-ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You **EVER** Suffered From?

\_\_\_\_AIDS \_\_\_\_Alcoholism \_\_\_\_Allergy Shots \_\_\_\_Anemia \_\_\_\_Appendicitis \_\_\_\_Arthritis \_\_\_\_Asthma

\_\_\_\_Bleeding \_\_\_\_Breast Lump \_\_\_\_Bronchitis \_\_\_\_Cancer \_\_\_\_Cataracts \_\_\_\_Chicken Pox \_\_\_\_Diabetes

\_\_\_\_Drug Dependency \_\_\_\_Emphysema \_\_\_\_Epilepsy \_\_\_\_Glaucoma \_\_\_\_ Goiter \_\_\_\_Gout

\_\_\_\_Heart Disease \_\_\_\_Hepatitis \_\_\_\_Hernia \_\_\_\_Herniated Disc \_\_\_\_Herpes \_\_\_\_High Blood Pressure

\_\_\_\_High Cholesterol \_\_\_\_Kidney/Liver Disease \_\_\_\_MS \_\_\_\_Measles \_\_\_\_Migraine Headaches

\_\_\_\_Miscarriage \_\_\_\_Mononucleosis \_\_\_\_Osteoporosis \_\_\_\_Pacemaker \_\_\_\_Parkinson’s Disease

\_\_\_\_Pinched Nerve \_\_\_\_Pneumonia \_\_\_\_Polio \_\_\_\_Prostrate Disorder \_\_\_\_Psychiatric Care

\_\_\_\_Rheumatoid Arthritis \_\_\_\_Rheumatic Fever \_\_\_\_Scarlet Fever \_\_\_\_Stroke \_\_\_\_Suicide Attempt

\_\_\_\_Thyroid Problems \_\_\_\_Tuberculosis \_\_\_\_Tumors/Growths \_\_\_\_Ulcers \_\_\_\_Vaginal Infection

\_\_\_\_Venereal Disease \_\_\_\_Whooping Cough

\_\_\_\_Other, Please Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Had Surgery\_\_\_\_\_\_\_\_\_ If So, Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Surgical Procedures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Surgical Procedures\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daily Activity: \_\_\_\_Mild/Light Activity \_\_\_\_\_Exercise Daily \_\_\_\_Exercise Occasional \_\_\_\_None

Habits: \_\_\_\_Smoking \_\_\_\_\_Amount Per Day

\_\_\_\_Alcohol \_\_\_\_\_Occasional \_\_\_Drinks Per Day

Caffeine Consumption: \_\_\_\_Cups/Day Soda Consumption: \_\_\_\_Glass/Day

Female Patients: \_\_\_\_ Are You Pregnant \_\_\_\_\_\_\_\_Date Of Last Cycle

If Applicable Was Pain During Childbirth \_\_\_\_Light \_\_\_\_Moderate \_\_\_\_Heavy

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND ACCURATE. I AUTHORIZE **LUNDGREN CHIROPRACTIC OFFICE** TO CONTACT ANY HEALTH CARE PROFESSIONALS, OFFICES, HOSPITALS AND/OR FACILITIES WHICH MAY HAVE RECORDS NEEDED TO COMPLETE MY FILE IN THIS OFFICE. I ALSO ASSIGN BENEFITS FROM MY INSURANCE COMPANY DIRECTLY TO **LUNDGREN CHIROPRACTIC OFFICE**. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE CARRIER. I HEREBY RELEASE ALL INFORMATION NEEDED TO SECURE PAYMENT OF THE BENEFITS AVAILABLE AND RELEASE MY SIGNATURE ON ALL CLAIM SUBMISSIONS. I AM AWARE THAT MY RECORDS WILL BE PURGED AFTER SEVEN YEARS OF INACTIVITY; HOWEVER, I AM ALSO AWARE THAT I MAY REQUEST A COPY OF SUCH RECORDS PRIOR TO SAID ACTION.

PATIENT/GUARDIAN SIGNATURE DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_