KEVIN S. MORIARTY, D.C.

WELCOME TO OUR OFFICE

NAME:_____ DATE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

AGE:_____ BIRTH DATE:_____ EMAIL:_____

SOCIAL SECURITY:_____

HOME#:_____ CELL#:_____ WORK#:_____

TYPE OF WORK:_____ EMPLOYER:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

SPOUSE NAME:_____ SPOUSE'S PH# _____

IN CASE OF EMERGENCY, PLEASE CONTACT:_____ PHONE:_____

PRIMARY CARE PROVIDER:_____ PHONE:_____

Our office will bill your insurance directly for services rendered. Remember that you are ultimately responsible for any charges incurred in this office. **It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not covered by your insurance or other third party payers. Your signature indicates that you agree to pay for any outstanding bills incurred in this office.** I authorize that payment be made directly to Kevin S. Moriarty, D.C. for any and all insurance benefits or reimbursement for services rendered by him. I also authorize the release of any information concerning my health and healthcare services to my insurance companies or other pre-paid healthcare plans. **I understand that there is no guarantee that my insurance companies or pre-paid healthcare plan will cover and pay for all of my charges, and I understand that I am responsible for all remaining charges.**

I hereby give permission to the doctor to administer treatment and perform general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition.

By signing this document, I agree and acknowledge the above statements.

_____ _____

Patient Signature Date

KEVIN S. MORIARTY, D.C.
Chiropractic
Acupuncture
Massage
Sports Medicine
505 W. Hollis St. - Suite 205
Nashua, NH 03062
(603) 595-7434
www.moriartychiro.com

OFFICE QUESTIONNAIRE

What is your **chief complaint** or primary reason for today's visit?

What are your **expectations or goals** for today's visit or future visits?

Is today's visit related to a **motor vehicle accident or work-related injury?**

How did you first hear about our office, and whom may we thank for **referring** you?

□ Internet

□ Advertisement

□ Friend/Family (name): _____

□ Drive by

□ Other _____

Name _____ Date:_____

Patient Name: _____ Date: _____

Current Medications	Strength	Frequency

Allergies? YES or NO	Severity	Describe Reaction
Medicine: _____	Mild/mod/severe	_____
Medicine: _____	Mild/mod/severe	_____
Medicine: _____	Mild/mod/severe	_____
Medicine: _____	Mild/mod/severe	_____
Food: _____	Mild/mod/severe	_____
Environmental: _____	Mild/mod/severe	_____

Smoking Status (age 13 and over): Current every day smoker Former smoker

Current some day smoker Never smoked

Clinic Use:

Height: _____ inches

Weight: _____ lbs.

Blood pressure: _____/_____

Name:_____ Date:_____ File:_____

PATIENT HISTORY

Please mark the appropriate box and explain your answer if necessary

No	Yes		
☐	☐	Headaches	_____
☐	☐	Neck pain	_____
☐	☐	Mid back pain	_____
☐	☐	Rib Pain	_____
☐	☐	Low back pain	_____
☐	☐	Sacroiliac pain	_____
☐	☐	Shoulders	_____
☐	☐	Elbows	_____
☐	☐	Wrists	_____
☐	☐	Hands/Fingers	_____
☐	☐	Hips/Pelvis	_____
☐	☐	Knee's	_____
☐	☐	Ankle's	_____
☐	☐	Feet/Toes	_____
☐	☐	Allergies(Meds/Envtl.)	_____
☐	☐	Dizziness/Vertigo	_____
☐	☐	Ringing in Ears/Tinnitus	_____
☐	☐	Numbness/Tingling	_____
☐	☐	Blurred/Double Vision	_____
☐	☐	Loss of Balance	_____
☐	☐	Eyes/Ears	_____
☐	☐	Nose/Throat	_____
☐	☐	Thyroid	_____
☐	☐	Sinus Condition	_____
☐	☐	Acid Reflux	_____
☐	☐	Gastrointestinal	_____
☐	☐	Nausea	_____
☐	☐	Diabetes	_____

No	Yes		
☐	☐	Heart Disease	_____
☐	☐	High Blood Pressure	_____
☐	☐	Cholesterol Problems	_____
☐	☐	Gall Bladder	_____
☐	☐	Breathing/Asthma	_____
☐	☐	Skin Disorders	_____
☐	☐	Auto Immune Disorder	_____
☐	☐	Anxiety/Depression	_____
☐	☐	Urinary/Kidney	_____
☐	☐	Prostate	_____
☐	☐	Breast or Uterine	_____
☐	☐	Birth Control Pills	_____
☐	☐	Knocked Unconscious	_____
☐	☐	Concussion	_____
☐	☐	Previous Car Accident	_____
☐	☐	Fractures/Dislocations	_____
☐	☐	Surgeries	_____
☐	☐	Hospitalizations	_____
☐	☐	Smoke	_____
☐	☐	Drink Alcohol	_____
☐	☐	Exercise	_____
☐	☐	Family History	_____
☐	☐	Married	_____
☐	☐	Children	_____
☐	☐	Prev. Chiropractic Care	_____
☐	☐	Other Conditions/Injuries	_____
☐	☐	Cancers	_____

COMMENTS:

_____

_____

_____

_____

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INSURANCE ASSIGNMENT & PAYMENT AGREEMENT

PATIENT NAME:_____

HEALTH CARE PAYMENT AGREEMENT: As a patient seeking treatment with health insurance,

I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I further understand and agree that this assignment, lien and authorization do not constitute any consideration for this office to await payment and will expect payment with accrued interest on any unpaid balance at a rate 1.5% per month. I also understand that I will be charged **$25.00** for any missed or canceled appointments if 24-hour notification was not given. **By signing this agreement I accept responsibility for unpaid charges to this provider.**

PATIENT SIGNATURE_____ **DATE**_____

MOTOR VEHICLE, WORKER'S COMPENSATION AND PERSONAL INJURY AGREEMENT: (ONLY)

As a patient seeking treatment due to a **Worker's Comp. Claim, Personal Injury or Motor Vehicle Accident, I** authorize and direct that payment be made directly to:

Dr. Kevin S. Moriarty Chiropractic Office

505 West Hollis St Nashua, Suite 205 NH 03062

for any sums as may be due and owing this chiropractic office for services rendered me, both by reason of accident, or illness or any other bills due this office and to withhold such sums from any disability benefits, medical payment benefits, no fault benefits, accident benefits, worker's compensation benefits or any insurance benefits, or from any settlement, judgment or verdict on my behalf. **I also understand I will be charged $25.00** for any **missed or canceled appointments if 24 hour notice was not** given. I further understand and agree thatthis assignment, lien, and authorization of this office will expect payment with accrued interest on unpaid balances at a rate of 1.5% per month. **This contract is to act as an assignment of my rights and benefits for the office charges and services provided herein.**

PATIENT SIGNATURE_____ **DATE** _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ Worse Pain Possible

0 1 2 3 4 5 6 7 8 9 10

1 - What is your pain RIGHT NOW?

No pain _____ Worse Pain Possible

0 1 2 3 4 5 6 7 8 9 10

2 - What is your TYPICAL or AVERAGE pain?

No pain _____ Worse Pain Possible

0 1 2 3 4 5 6 7 8 9 10

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ Worse Pain Possible

0 1 2 3 4 5 6 7 8 9 10

4 - What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ Worse Pain Possible

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Patient Name _____ Date _____

Mark the areas on this body where you feel the described sensations.

Use the appropriate symbols

Mark areas of radiation

Include affected areas

Numbness	Pins and needles	Burning	Aching	Stabbing
----------	0000000	xxxxxxx	*******	//////////