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:_____

WELCOME TO OUR OFFICE

NAME:_____DATE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

AGE:_____, BIRTH DATE:_____ EMAIL:_____

SS#:_____**(VA PATIENTS ONLY)**

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

QUADRUPLE VISUAL ANALOG SCALE

Patient Name_____ Date_____

Please read carefully:

Please circle the number that best describes the question being asked. If you have more than one complaint, for example, neck pain and low back pain, please write the complaint above the number.

Please answer all 4 questions

---

1. What is your pain **RIGHT NOW**?

No pain _____ Worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain_____ Worst possible pain
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 you pain get at its best)?

No pain_____ Worst possible pain
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 you pain get)?

No pain_____ Worst possible pain
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____ _____

_____

Name_____

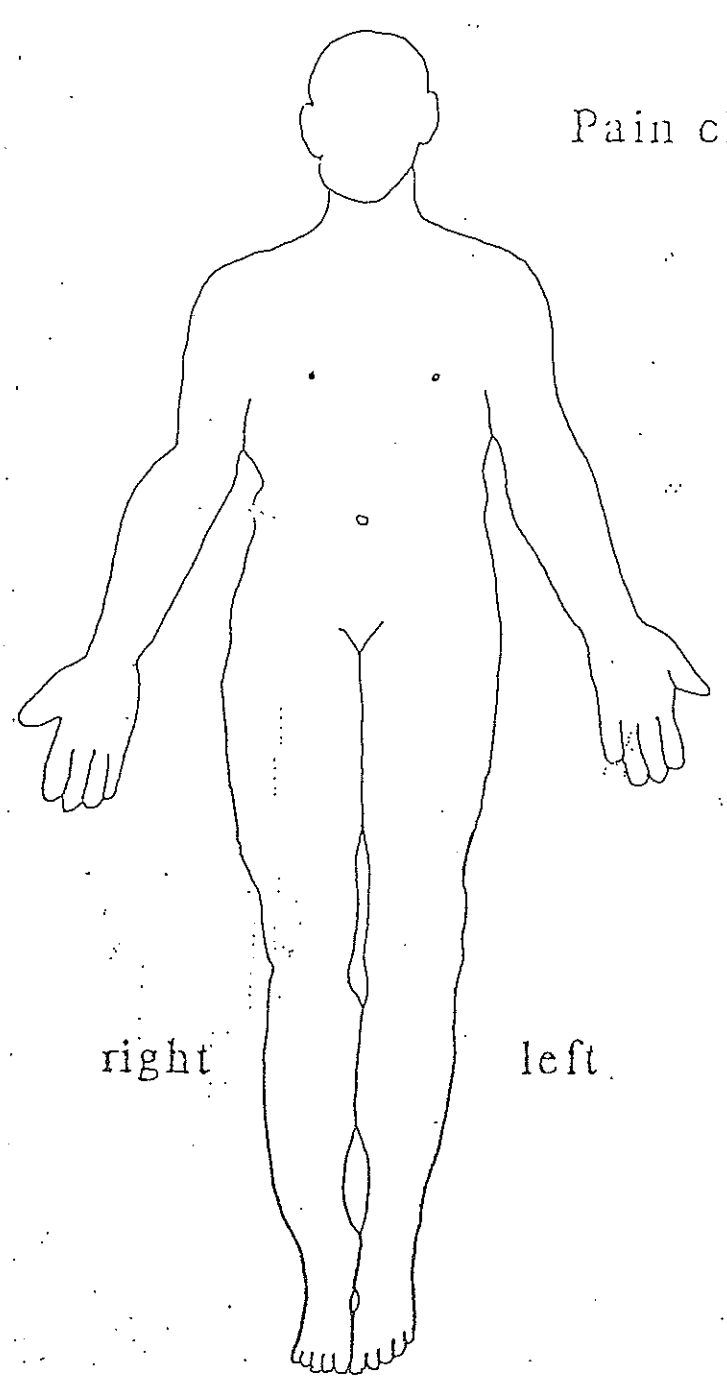
File_____

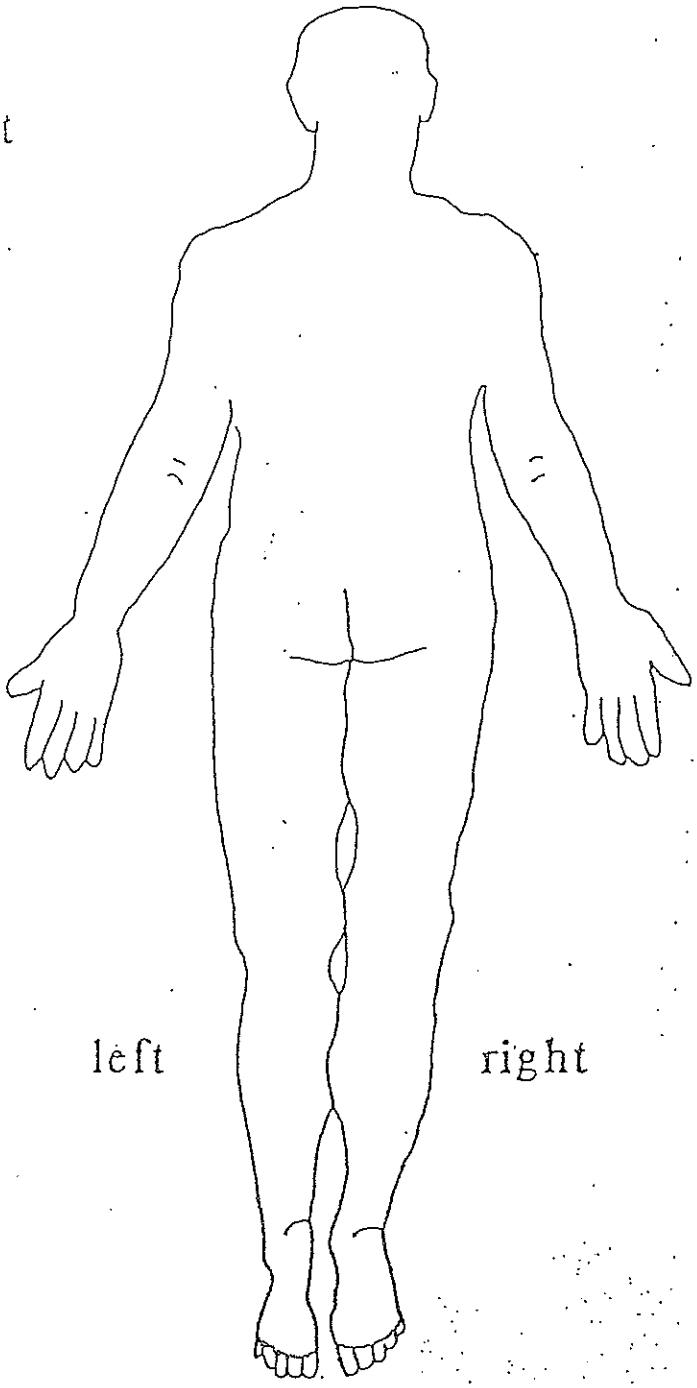
Date_____

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Pain chart





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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 _____

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:

_____

_____

_____

_____