Perrault Chiropractic Offices, Inc.

New Patient Information Packet
About the documents in this packet

The best and most efficient way to complete your office intake forms is online. By going to www.PerraultChiropractic.com and selecting the *Downloads* tab. There you will find the link that allows you to complete and submit all your paperwork online. If at all possible, please use the online link and avoid additional paperwork.

If you are unable to complete your intake information online, you can complete the forms in this packet and get them to our office before your appointment. Please, take the time you need to complete the forms in detail. Providing complete and detailed information helps us to serve you better, establish your personal healthcare record and vital health history – all of which is valuable to your doctor and allows the staff to process your insurance claims efficiently.

Please read this instruction page and fill out all forms in detail to the best of your ability. If you have questions call us at 978-686-7791 and speak with any of our staff members.

When you have completed the forms you can:

- Fax the completed forms to 978-975-0468
- Drop the forms off at the office anytime before your appointment
- Bring them with you 30 minutes prior to your scheduled appointment time.
- ***The earlier we receive the forms, the easier it is to proceed through the first visit.***

Patient Registration & Health History (2 pages) – This form gathers demographic information and some basic health information (Do not include the problem that is bringing you into the office. That information will be detailed in the ***Problem Detail*** form). Please be sure to provide your mobile phone number and email address so that we can contact you if there is a change in scheduling and send appointment reminders.

Problem Detail Forms (2 copies) – It's here where you'll detail the issues surrounding your current problem. *Be as specific as possible* as it helps your doctor better understand your condition. *Use one form for each complaint that you may be experiencing*. For example, if you are suffering from neck pain with headaches and some low back pain, you should fill out three copies of this form, one each for the neck, headache and low back.

Family History Form (1page) – Provides a health history of blood relatives.

We appreciate the opportunity to be of service to you and your family. Thank you for your cooperation in completing these forms so that we may provide better service. Please feel free to call the office if you have any questions.

The Doctors & Staff of Perrault Chiropractic Offices, Inc.

Patient Registration & Health History

Today's Date: _____/_____/_____ **Signature of Patient** _____

Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

Name
First: _____ **Middle:** _____ **Last:** _____**Suffix**_____

Nick Name: _____ **Date of Birth:** _____/_____/_____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

SSN _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Home Phone _____ **Work Phone** _____

Mobile Phone _____ **Email** _____

Mobile Phone Provider (Allows for appointment reminders via Text Message): ❑ Verizon ❑ AT&T ❑ T-Mobile ❑ Sprint ❑ Nextel ❑ US Cellular ❑ Virgin Mobile ❑Boost Mobile ❑ Cricket ❑ Metro-PCS

Preferred Contact Method: ❑ Mobile Phone ❑ Home Phone ❑ Work Phone ❑ Email ❑ Patient Portal

Employment Status *(check one)*: ❑ Employed (❑Full Time ❑Part Time) ❑ Self Employed ❑ Retired ❑ Disabled ❑ Student (❑Full Time ❑Part Time) ❑ Other

Marital Status *(check one)* ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Race *(check one)* ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian or other Pacific Island ❑ White ❑ I choose not to specify

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ French ❑ Portuguese ❑ Chinese ❑ American Sign
❑ Korean ❑ Italian ❑ Russian ❑ Polish ❑ Arabic ❑ German
❑ Vietnamese ❑ Other: _____ ❑ I choose not to specify

Clinical Summary: ☐ **I choose to decline receipt of my clinical summary after every visit**
☐ **I choose to receive a clinical summary after every visit**
(These summaries are often blank because of the nature and frequency of chiropractic care.)

Smoking Status: ❑ Current daily smoker ❑ Current some days smoker ❑ Former smoker ❑ Never a smoker

If you do smoke, how much and how often? _____ Pack(s) per ____ Day
Smoking Start Date (Optional): _____ Smoking Quit Date (Optional): _____
Interest in quitting: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (0 = no interest, 10 = extremely interested)

Allergies to Medications: ❑ I have no known drug allergies

List any known allergies to any medications: _____

Over to Complete Other Side ⇨

Please list your current medications, including dosage. ❑ Medication List attached
❑ I'm not currently taking any medications

Dosage Dosage

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

Briefly list your main health concerns: _____

_____

Have you been diagnosed with: ❑ **High Blood Pressure** ❑ **Asthma** ❑ **Diabetes (**❑ Type 1 ❑ Type 2)

Other diagnosed condition(s): _____

Previous Health History: Please provide an explanation to any answer you mark "Yes". If you need more space, use the space provided in the section marked "Additional Comments".

Childhood:

Childhood diseases: ❑ No ❑ Yes _____

Serious falls/accidents: ❑ No ❑ Yes _____

Medications or Drug use: ❑ No ❑ Yes _____

Vaccinated: ❑ No ❑ Yes _____

Surgeries: ❑ No ❑ Yes _____

Youth sports: ❑ No ❑ Yes _____

Chiropractic Care: ❑ No ❑ Yes _____

Adult (18+):

Alcohol Use: ❑ No ❑ Yes *If yes*, ❑ Daily ❑ Weekly ❑ Socially ❑ Rarely ❑ No longer

Caffeine: ❑ No ❑ Yes *If yes*, ❑ Rarely ❑ Socially ❑ 1 to 2 cups daily ❑ 3+ cups daily

Serious falls/accidents: ❑ No ❑ Yes _____

Surgeries: ❑ No ❑ Yes _____

Sports: ❑ No ❑ Yes _____

Regular Exercise: ❑ No ❑ Yes *If yes, How often and what do you do?*:_____

_____

Chiropractic Care: ❑ No ❑ Yes _____

Additional Comments:

_____

_____

_____

_____

_____

Current: **Height:** _____ inches **Weight:** _____ pounds **Pulse**: _____ bpm **BP:** _____/_____

Over to Complete Other Side ⇨

Perrault Chiropractic Offices, Inc. **Problem Detail Form** Date: _____

Patient Name: _____ **Date of Birth:** _____

To best help the doctor to understand your problem complete this form in detail.

Describe ONLY 1 problem on this page - Use a separate form for each problem area.

Where do you feel the problem? _____

_____

What caused the problem? _____

When did this begin? _____

Circle the level of pain you have been experiencing. (0 = No pain, 10 = Excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

What activities of daily living are most affected? ☐ Employment ☐ Homemaking ☐ Lifting
☐ Personal Care ☐ Sitting ☐ Sleeping ☐ Social life ☐ Standing ☐ Traveling and/or Driving
☐ Walking ☐ Other: _____

What tasks do you have difficulty performing due to this problem (Check all that apply): ☐ Bending over
☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing self ☐ Driving car ☐ Exercising
☐ Getting in/out of car ☐ Getting to sleep ☐ Grocery shopping ☐ Performing household chores
☐ Lifting ☐ Looking over shoulder ☐ Lying down ☐ Making love ☐ Reaching overhead
☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing ☐ Staying asleep
☐ Using a computer ☐ Walking ☐ Yard work ☐ Other: _____

_____

My pain is:

☐ Dull	☐ Stabbing	☐ Deep	☐ Sharp	☐ Sharp with movement
☐ Throbbing	☐ Burning	☐ Aching	☐ Soreness	☐ Pulling
☐ Cramping	☐ Numbness	☐ Tingling	☐ Pinprick	☐ Radiating
☐ Tightness	☐ Pressure	☐ Stiffness	☐ Weakness	☐ Pins and needles
☐ Heaviness	☐ Shooting	☐ Pinching	☐ Other: _____	

The pain has been: ☐ Constant ☐ Frequent ☐ Intermittent ☐ Off and on ☐ Random ☐ Recurring
My pain is at its worst in the: ☐ morning ☐ afternoon ☐ evening ☐ at night

Does the pain radiate? ☐ No ☐ Yes, the pain radiates to: _____

My pain is:

☐ Dull	☐ Sharp	☐ Sharp with movement	☐ Stabbing
☐ Deep	☐ Throbbing	☐ Burning	☐ Aching
☐ Soreness	☐ Pulling	☐ Cramping	☐ Numbness
☐ Tingling	☐ Pinprick	☐ Radiating	☐ Tightness
☐ Pressure	☐ Stiffness	☐ Weakness	☐ Pins and needles
☐ Heaviness	☐ Shooting	☐ Pinching	☐ Other: _____

What helps relieve the problem?
☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage ☐ Nothing
☐ Over the counter medication ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ Other: _____

What helps relieve the problem?
☐ Chiropractic adjustment ☐ Cold packs ☐ Exercise ☐ Heat packs ☐ Massage ☐ Nothing
☐ Over the counter medication ☐ Physical therapy ☐ Prescription medication ☐ Re-direct attention
☐ Rest ☐ Stretching ☐ Work ☐ Other: _____

Have you had previous episodes of this problem? ☐ No ☐ Yes _____

Have you had care previous to coming here for this problem? ☐ No ☐ Yes _____

Have you had recent diagnostic tests for this problem? ☐ No ☐ Yes _____

Returning Patients: Since you were last here, any new Surgeries, Traumas, Illnesses or Medications?

☐ No ☐ Yes _____

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What caused the problem? _____

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☐ Walking ☐ Other: _____

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☐ Caring for family ☐ Climbing stairs ☐ Concentrating ☐ Dressing self ☐ Driving car ☐ Exercising
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☐ Rising out of chair or bed ☐ Showering or bathing ☐ Sitting ☐ Standing ☐ Staying asleep
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_____

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☐ Rest ☐ Stretching ☐ Work ☐ Other: _____

Have you had previous episodes of this problem? ☐ No ☐ Yes _____

Have you had care previous to coming here for this problem? ☐ No ☐ Yes _____

Have you had recent diagnostic tests for this problem? ☐ No ☐ Yes _____

Returning Patients: Since you were last here, any new Surgeries, Traumas, Illnesses or Medications?

☐ No ☐ Yes _____

Family History Form Patient: _____ Date:_____

Please provide the following information regarding the health conditions of your primary relations.

Condition	Father	Mother	Brother	Sister	Son	Daughter
No Known History	☐	☐	☐	☐	☐	☐
Cancer Specify Type Here →	☐	☐	☐	☐	☐	☐
Clotting Disorder (including Deep Vein Thrombosis, Pulmonary Embolism) Specify Type Here →	☐	☐	☐	☐	☐	☐
Dementia/Alzheimer's	☐	☐	☐	☐	☐	☐
Diabetes (including Pre-diabetes, Type 1 & 2, Insulin resistant, Gestational) Specify Type Here →	☐	☐	☐	☐	☐	☐
GI Disorder (Including Crohn's, FAP, Colon Polyp, IBS, Lynch syndrome, Ulcerative Colitis, Unknown GI disorder) Specify Type Here →	☐	☐	☐	☐	☐	☐
Heart Disease (Including Angina, Coronary Artery Disease, Heart Attack, Heart Disease, Unknown) Specify Type Here →	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Kidney Disease (including Cystic Kidney, Nephrosis, Nephritis, Nephrotic Syndrome, Other Kidney Disease, Unknown) Specify Type Here →	☐	☐	☐	☐	☐	☐
Lung Disease (includes Asthma, COPD, Chronic Bronchitis, Chronic Lower Resp. Disease, Emphysema, Flu, Pneumonia, Unknown) Specify Type Here →	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Psychological Disorder (Anxiety, ADD/ADHD, Autism, Bipolar, Depression, Eating Disorder, OCD, Panic Disorder, Personality Disorder, PTSD, Schizophrenia, Social Phobia, Unknown) Specify Type Here →	☐	☐	☐	☐	☐	☐
Septicemia	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
SIDS	☐	☐	☐	☐	☐	☐

Any additional information you would like to provide: