PATIENT NAME_____ DATE_____

Date of Birth___/____/____ Sex ___ Cell Phone_____Email_____

Address_____City_____St_____ZIP_____

Emergency Contact/Phone_____Marital Status___

Ins Company_____ Member ID _____ Primary Subscriber_____

Primary Address_____City_____St_____ZIP_____

Primary DOB___/___/___ Sex___ Relationship to Primary _____ Primary Phone _____

THIS PROBLEM FIRST EVER STARTED: _____/_____/_____

BUT RECENTLY BEGAN/ WORSENED: _____/_____/_____

HOW DID THIS HAPPEN? EXPLAIN IN DETAIL.

_____

_____

_____

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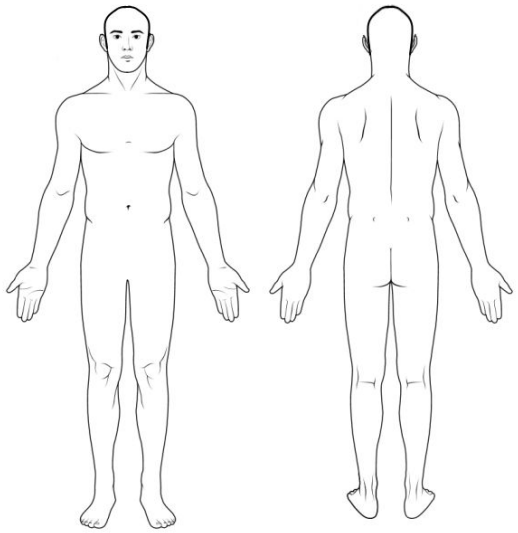
_____

_____

MARK ALL AFFECTED AREAS



WHAT ACTIVITIES MAKE YOU FEEL BETTER:

WHAT ACTIVITIES MAKE YOU FEEL WORSE:

LIST SURGERIES • HOSPITALIZATIONS • ACCIDENTS • MAJOR INJURIES • DIAGNOSIS OF DISEASE

_____(INCLUDE YEAR)_____

_____

_____

_____

LIST PRESCRIBED MEDICATIONS • OTC MEDICATIONS • SUPPLEMENTS

_____

_____

_____

PATIENT NAME_____

HAVE YOU OR AN IMMEDIATE FAMILY MEMBER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

☐Stroke ☐Cancer ☐Diabetes ☐ Hypertension ☐Neurological disorders ☐Osteoporosis ☐Autoimmune

Explain:

HAVE YOU RECENTLY NOTICED ANY OF THE FOLLOWING?

☐changes in vision ☐blurry vision ☐double vision ☐changes in speech ☐slurred speech ☐difficulty finding words ☐headaches ☐dizziness ☐numbness in body or face ☐weakness ☐fatigue ☐lightheadedness ☐nausea

Explain:

MUSCULOSKELETAL ☐arthritis ☐back problems ☐disc or spine injury ☐cramping ☐fracture ☐gout ☐implants or plates ☐pins or screws ☐joint or muscle pains/stiffness ☐knee injuries ☐osteoporosis ☐poor posture ☐scoliosis ☐swelling ☐jaw issues

NEURO: ☐anxiety ☐depression ☐difficulty concentrating ☐dizziness ☐seizures ☐headache ☐loss of smell or taste ☐memory issues ☐numbness ☐pins and needles ☐sleeping issues ☐stroke ☐ loss of vision ☐smell or hearing

CARDIO/PULM: ☐blood clots ☐chest pain or tightness ☐congenital heart defects ☐coronary artery disease ☐dizziness ☐excessive bruising ☐heart attack ☐heart murmur ☐high blood pressure ☐high cholesterol or triglycerides ☐leg pain upon walking ☐low blood pressure ☐lower extremity edema ☐palpitations ☐swollen legs or feet ☐varicose veins ☐apnea ☐asthma ☐blood in sputum ☐emphysema ☐hay fever ☐persistent cough ☐pneumonia ☐shortness of breath ☐snoring issues ☐tuberculosis and wheezing ☐smoke ____ packs/ a day

ORGAN HISTORY ☐abdominal pain ☐black or bloody stool ☐bloating ☐changes in bowel habits ☐colitis ☐colon cancer or colon polyps ☐constipation ☐difficulty swallowing ☐Crohn's disease ☐food sensitivities ☐gastric reflux ☐heartburn ☐hemorrhoids ☐irritable bowel syndrome ☐jaundice ☐liver disease ☐nausea or vomiting ☐pancreatitis ☐severe diarrhea ☐ulcer and vomiting ☐drink alcohol regularly ☐changes with urine/urination ☐incontinence ☐kidney stones ☐painful or frequent urination ☐Cushing's syndrome ☐diabetes ☐excessive thirst ☐feeling hot or cold all the time ☐heat or cold intolerance ☐hyperparathyroidism ☐hyperthyroidism ☐hypothyroidism ☐increase size of hands or feet ☐increase urination ☐pancreatic conditions ☐polydipsia ☐polyuria ☐purple striae ☐steroid treatments ☐testosterone deficiency ☐change in hair or nails ☐easy bruising ☐eczema ☐excessive acne ☐excessive hair loss ☐gum bleeding ☐flushing ☐hyper/hypo pigmentation ☐psoriasis ☐skin cancer ☐skin trouble or rashes ☐blurred or double vision ☐cataracts ☐chronic ear infections ☐dental problems ☐difficulty swallowing ☐ear or hearing problems ☐eye or vision problems ☐earache ☐eye surgery ☐eyeglasses or contact lenses ☐glaucoma ☐headaches or migraines ☐hoarseness ☐nose congestion or sinus trouble ☐postnasal drip ☐recent hearing loss ☐ringing in the ears ☐sore throat ☐swollen lymph nodes

MEN'S HEALTH ☐Pain or lump in testicles ☐Prostate problems ☐Difficulty with erection ☐Prostate exam

WOMEN'S HEALTH ☐Pregnant ☐Nursing ☐Taking Birth Control ☐ Irregular Periods ☐Breast Implants

ALLERGIES:

HIPAA

NJ NERVE
CHIROPRACTIC & REHAB

HIPAA - Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices and the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained. In addition, I authorize NJ Nerve to communicate protected health information through the use of phone, voice-mail, text messages, and personal communication, i.e. birthday cards, thank you notes, etc., as well as including electronic communication such as announcements or newsletters. The phone number(s), e-mail address, and address that I have provided are the correct points of contact for the previous means of correspondence and outreach for me.

Release of Health Information and Assignment of Benefits

I authorize NJ Nerve to use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, replying to requests from my insurance company, evaluating the quality of services provided, communicating with my referring physician, and any other operations related to treatment or payment as noted in the Notice of Privacy Practices.

_____

Patient Name

_____ _____

Patient or Guardian Signature **Date**

Patient Agreement

NJ NERVE
CHIROPRACTIC & REHAB

Consent For Care

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I understand that any medical procedure poses certain risks and that there may be rare instances of injury following manual therapies, modalities, and manipulation.

Authorization for Care Covered by Insurance

Treatments and plans for care are authorized by the doctor and follow specific and strict clinical guidelines.

Insurance companies define medical necessity as a care plan designed to improve a condition.
A plan is no longer considered medically necessary if the patient has acheived maximum therapeutic benefit, which means no further improvement can be made for the condition.

To attempt to utilize medical benefits, visits must be performed within the recommended and authorized treatment plans set by the doctors. Otherwise, insurance payment is not guaranteed and the patient will be responsible for the balance of the full visit cost including any elective therapies.

Visit frequency depends on justification for care determined only by the doctor.

Payment by Insurance Companies

I understand that benefits quoted from my insurance carrier to this clinic are only an estimate and not a guarantee of payment and I assign this office all benefits payable to me under my insurance policies and health benefit plans.

Patient Responsibility

I shall be personally responsible for any unpaid balance.

This office reserves the right to change, modify, or terminate any careplan, payment package, and/or pre-payment of care as it sees fit or as is or becomes medically necessary for any and all existing or new conditions or circumstance.

If I do not have insurance, you are responsible for all charges to your account based on your treatment by the providers.

I, the undersigned, understand and agree to this Patient Agreement.

>> _____

Patient Name

>> _____ _____

Patient or Guardian Signature **Date**

NJ NERVE
CHIROPRACTIC & REHAB

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination(s) of myself which NJ Nerve Chiropractic and Rehab may consider necessary or advisable in the course of my examination and treatment.

Females: Regarding Possibility of Pregnancy

Certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child. Please choose:

❒ It is NOT AT ALL possible that I could be pregnant.

❒ Prepubescent ❒ Post-Menopausal ❒Not Sexually Active

❒ Oral Contraceptives ❒IUD/ Device ❒Other, Explain _____

Best estimate of First day of last menstrual period_____

❒ It is possible that I could be pregnant.

****Important** - First day of last menstrual period_____**

Patient Name:_____

Signed _____ Date _____

Guardian_____