Patient Name_____ Today's Date_____
Phone (_____)_____-_____E-mail_____
Address_____
City_____State_____Zip Code_____
Date of Birth _____/_____/_____ Gender [ ] Male [ ] Female
Emergency Contact_____Emergency Contact Phone_(_____)_____-_____

Insurance Information

Ins Company_____ Member ID _____
Primary Subscriber Name_____ Primary DOB_____/_____/_____
Address_____City_____St_____ZIP_____
[ ]Male [ ]Female Relationship _____ Prim Phone _____

Patient Agreement

Informed Consent - 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. I understand that the more common side effects of Chiropractic treatment are muscle, joint, nerve, or skin irritation and soreness. Although extremely rare, manipulation could possibly cause more severe injuries to the joints, bones, or blood vessels in older populations or those with pre-existing conditions.

Authorization For Care - Treatments and plans for care are authorized by the doctor and follow specific and strict clinical guidelines. Medical necessity is defined as a care aimed at improving a condition. A plan is no longer considered medically necessary if the patient has achieved maximum therapeutic benefit, which means no further improvement can be made for the condition. At some point you may attempt to utilize medical benefits from insurance or any third party payer. If so, 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.

Patient Responsibility - I shall be personally responsible for any balance or unpaid balance by a third party payer. Benefits quoted from insurance carriers or third party payers are only an estimate and not a guarantee of payment and I assign all benefits payable to me under my insurance policies and health benefit plans if I choose to use any sort of reimbursement. This office reserves the right to change, modify, or terminate any care plan, 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 circumstances. If you do not have insurance, you are responsible for all charges to your account based on your treatment by the providers.

>>>> I understand and agree to this Patient Agreement. **>>>>**Signed: _____

HIPAA Agreement

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.

>>>>I acknowledge receipt of Privacy Practices **>>>>**Signed: _____

Patient Consent To X-ray

The doctor may find it necessary or beneficial to take x-rays of the spine, shoulder, hips, or other joints. X-rays can be used to look for new or old problems which might affect the outcome of care, like old fractures, arthritis, deformations, or congenital anomalies. X-rays can also be used to assess the spine and aid in analysis.

FEMALES ONLY

[ ] It is possible that I may be pregnant [ ] It is not possible that I may be pregnant [ ] I am not sure
IF ANSWERED NOT POSSIBLE, WHY? [ ] Not sexually active [ ]Pre-pubescent [ ]Birth Control Pill [ ]IUD
[ ] Cannot become pregnant [ ]Hysterectomy/Surgical [ ]Menopause

PLEASE ENTER THE FIRST DAY OF LAST MENSTRUAL PERIOD:_____/_____/_____

>>>>I consent to any necessary x-rays. **>>>>**Signed: _____

Patient Name_____

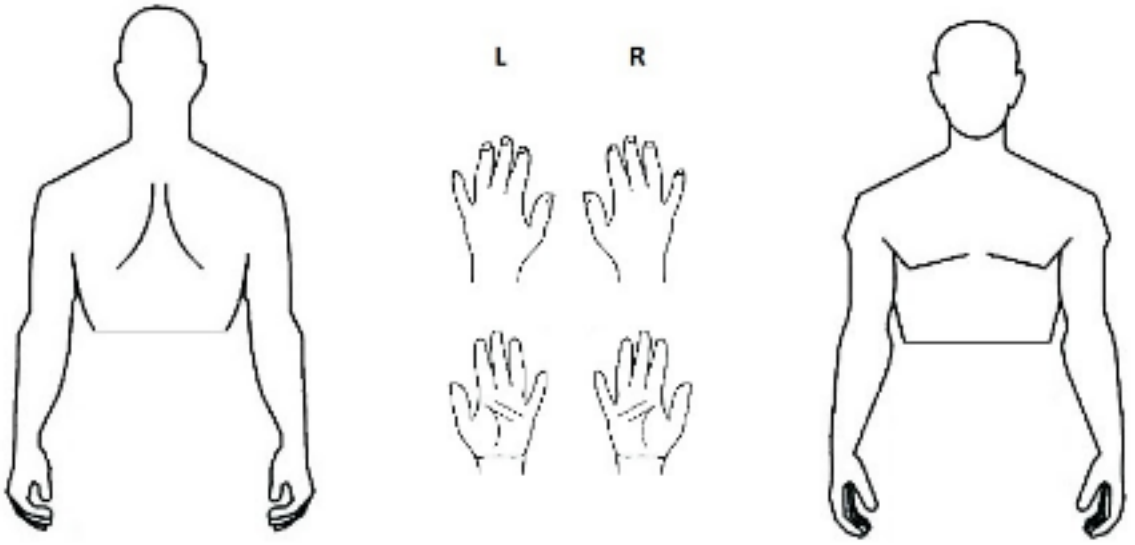
UPPER REGION HISTORY

[ ] I have NO issues in this upper region *(then skip this page)* [ ] I have an old, chronic issue in this upper region
[ ] I have a new exacerbation/ worsening of a chronic condition [ ] I have a NEW issue in this region

DRAWING INSTRUCTIONS:

DARKEN/ FILL IN
AREAS OF
--NUMBNESS
--BURNING
--TINGLING
--WEAKNESS

CIRCLE/ ARROW
AREAS OF
--PAIN
--DISCOMFORT
--ACHE
--STIFFNESS



•**THIS PAIN WAS FIRST EVER EXPERIENCED** [ ] YEARS AGO [ ] MONTHS AGO [ ] WEEKS AGO [ ] DAYS AGO [ ] TODAY
•BEST ESTIMATE OF THE MOST RECENT DATE OF WORSENING: _____/_____/_____
•**WHICH PRECEDING FACTORS DO YOU THINK CAUSED THIS?** [ ] Auto Accident [ ]Slip/ Fall [ ]Sports [ ]Exercise [ ]Lifting Object [ ]Childcare [ ]Repetitive Movements [ ]Strenuous Job [ ]Sedentary Lifestyle [ ]Sitting long hours [ ]Long commute/ Traveling [ ]Poor Sleep [ ]Childhood injury [ ]Adulthood injury [ ]Poor Posture [ ]Genetics/Family [ ]Arthritis [ ]Disc Issues [ ]Previous Surgeries [ ]Overweight [ ]Poor Nutrition [ ] Pregnancy [ ]Compensating other injury [ ]OTHER:
•**WHAT RECENT FACTORS HAVE LED TO THIS CHIROPRACTIC VISIT?** [ ]Physical stress [ ]Mental Stress [ ]Inflamed [ ]Injury not healing [ ]Muscle pain worsening [ ]Nerve pain worsening [ ]Arthritic Pain [ ]Joint pain flaring up [ ]Not able to run [ ]Impaired sleep [ ]Not able to relax without pain [ ]Not able to work without pain [ ]Not able to drive without pain [ ]Not able to exercise/walk/run without pain [ ]Not able to function and live the way I want to [ ]Pain is affecting my life [ ]Computer Use [ ]Home Improvement [ ]Intense Activities [ ]Cleaning [ ]Yardwork [ ]Chores [ ]Standing [ ]Sitting [ ]OTHER:
• **ADDITIONAL DETAILS ABOUT WHAT CAUSED OR CONTRIBUTED TO THIS:**

CHECK OFF THE BOX IF THE FOLLOWING “WORSENS” OR “RELIEVES” YOUR PAIN, OR IF IT STAYS THE “SAME”

Activity	WORSENS	RELIEVES	SAME		Movement	WORSENS	RELIEVES	SAME
Walking					**Looking over shoulder**			
Sitting					**Bringing head to chest**			
Standing					**Looking up**			
Relaxing					**Using arm/ shoulder**			
Exercise					**Reaching overhead**			
Sleep					**Cough/Sneeze**			
Working					**Lifting Objects**			

Patient Name_____

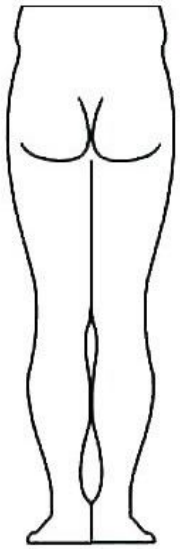
LOWER REGION HISTORY

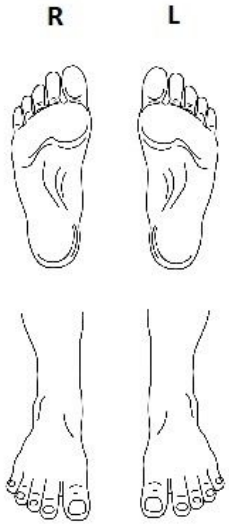
[ ] I have NO issues in this lower region *(then skip this page)* [ ] I have an old, chronic issue in this lower region
[ ] I have a new exacerbation/ worsening of a chronic condition [ ] I have a NEW issue in this lower region

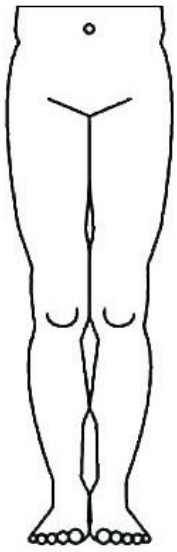
DRAWING INSTRUCTIONS:

DARKEN/ FILL IN
AREAS OF
--NUMBNESS
--BURNING
--TINGLING
--WEAKNESS

CIRCLE/ ARROW
AREAS OF
--PAIN
--DISCOMFORT
--ACHE
--STIFFNESS







•THIS PAIN WAS FIRST EVER EXPERIENCED [ ] YEARS AGO [ ] MONTHS AGO [ ] WEEKS AGO [ ] DAYS AGO
•BEST ESTIMATE OF THE MOST RECENT DATE OF WORSENING: _____/_____/_____
•WHICH PRECEDING FACTORS DO YOU THINK CAUSED THIS? [ ] Auto Accident [ ]Slip/ Fall [ ]Sports [ ]Exercise
[ ]Lifting Object [ ]Childcare [ ]Repetitive Movements [ ]Strenuous Job [ ]Sedentary Lifestyle [ ]Sitting long hours
[ ]Long commute/ Traveling [ ]Poor Sleep [ ]Childhood injury [ ]Adulthood injury [ ]Poor Posture [ ]Genetics/Family
[ ]Arthritis [ ]Disc Issues [ ]Previous Surgeries [ ]Overweight [ ]Poor Nutrition [ ] Pregnancy [ ]Compensating other injury
[ ]OTHER:
•WHAT RECENT FACTORS HAVE LED TO THIS CHIROPRACTIC VISIT? [ ]Physical stress [ ]Mental Stress [ ]Inflamed
[ ]Injury not healing [ ]Muscle pain worsening [ ]Nerve pain worsening [ ]Arthritic Pain [ ]Joint pain flaring up [ ]Not able to run
[ ]Impaired sleep [ ]Not able to relax without pain [ ]Not able to work without pain [ ]Not able to drive without pain
[ ]Not able to exercise/walk/run without pain [ ]Not able to function and live the way I want to [ ]showering/dressing
[ ]Computer Use [ ]Home Improvement [ ]Intense Activities [ ]Cleaning [ ]Yardwork [ ]Chores [ ]Standing [ ]Sitting
[ ]OTHER:
• ADDITIONAL DETAILS ABOUT WHAT CAUSED OR CONTRIBUTED TO THIS:

CHECK OFF THE BOX IF THE FOLLOWING “WORSENS” OR “RELIEVES” YOUR PAIN, OR IF IT STAYS THE “SAME”

Activity	WORSENS	RELIEVES	SAME		Movement	WORSENS	RELIEVES	SAME
Walking					**Bending Forward**			
Sitting					**Extending Back**			
Standing					**Twist to Right**			
Relaxing					**Twist to Left**			
Exercise					**Squatting**			
Sleep					**Cough/ Sneeze**			
Working					**Lifting Leg**			

Patient Name_____

ORGAN SYSTEM REVIEW

CARDIOVASCULAR HISTORY [ ] No reported cardiovascular symptoms or conditions, surgeries, or medications.

[ ] saw cardiologist	[ ] dizziness	[ ] heart murmur	[ ] rheumatic fever
[ ] saw other physician	[ ] dyspnea	[ ] high blood pressure	[ ] swollen legs or feet
[ ] blood clots	[ ] heart attack	[ ] low blood pressure	[ ] pacemaker
[ ] chest pain or tightness	[ ] palpitations	[ ] high cholesterol	[ ] Stent
[ ] congenital heart defects	[ ] coronary artery disease	[ ] lower extremity edema	[ ] leg pain upon walking

Please list any **CARDIOVASCULAR Surgeries** and/or **Medications** with relevant dates and details

LUNG HISTORY [ ] No reported pulmonary symptoms or conditions, surgeries, or medications.

[ ] saw pulmonologist	[ ] blood in sputum	[ ] shortness of breath	[ ] COPD
[ ] saw other physician	[ ] emphysema	[ ] snoring issues	[ ] wheezing
[ ] apnea	[ ] persistent cough	[ ] tuberculosis	[ ] asthma

Please list any **LUNG Surgeries** and/or **Medications** with relevant dates and details

NEUROLOGICAL HISTORY [ ] No reported neurological symptoms or conditions, surgeries, or medications.

[ ] saw neurologist	[ ] nerve issues	**POSSIBLE SIGNS OF STROKE**	[ ] memory loss
[ ] saw other physician	[ ] concussion	[ ] severe headache	[ ] loss of sensation
[ ] stroke	[ ] brain disorder	[ ] worst headache ever	[ ] dizziness
[ ] TIA	[ ] migraine	[ ] difficulty swallowing	[ ] loss of balance
[ ] Parkinsons	[ ] seizures	[ ] slurred speech	[ ] weakness face/body
[ ] tremors/shaking	[ ] neuro disease	[ ] numb/tingling face/body	[ ] changes in vision

Please list any **NEUROLOGICAL Surgeries** and/or **Medications** with relevant dates and details

GASTROINTESTINAL HISTORY [ ] No reported gastrointestinal symptoms or conditions, surgeries, or medications.

[ ] saw gastro specialist	[ ] changes in bowel habits	[ ] food sensitivities	[ ] diarrhea
[ ] saw other physician	[ ] constipation	[ ] gastric reflux	[ ] liver issues
[ ] abdominal pain	[ ] colon issues	[ ] heartburn	[ ] vomiting
[ ] black/bloody stool	[ ] Crohn's disease	[ ] hemorrhoids	[ ] pancreas issues
[ ] bloating	[ ] ulcer	[ ] irritable bowel	[ ] leg pain upon walking

Please list any **GASTROINTESTINAL Surgeries** and/or **Medications** with relevant dates and details

SKIN HISTORY [ ] No reported dermatological symptoms or conditions, surgeries, or medications.

[ ] saw dermatologist	[ ] eczema	[ ] skin cancer	[ ] easy bruising
[ ] saw other physician	[ ] psoriasis	[ ] skin issues	[ ] change in hair/nails

Please list any **SKIN Surgeries** and/or **Medications** with relevant dates and details

Patient Name_____

GENITOURINARY HISTORY [ ] No reported genitourinary symptoms or conditions, surgeries, or medications.

[ ] saw physician	**MALE ISSUES**	**FEMALE ISSUES**	[ ] recurrent fungal infections
[ ] incontinence	[ ] low testosterone	[ ] past pregnancy	[ ] breast pain
[ ] kidney stones	[ ] erectile issues	[ ] current pregnancy	[ ] breast lumps
[ ] painful urination	[ ] testicular pain	[ ] painful periods	[ ] breast cancer
[ ] frequent urination	[ ] testicular issues	[ ] endometriosis	[ ] surgery of breast
[ ] urinary infections	[ ] prostate issues	[ ] uterine issues	[ ] ovarian issues

Please list any **GENITOURINARY Surgeries** and/or **Medications** with relevant dates and details

ENDOCRINE HISTORY [ ] No reported endocrine symptoms or conditions, surgeries, or medications.

[ ] saw endocrinologist	[ ] excessive thirst	[ ] tired after eating	[ ] Cushing's
[ ] saw physician	[ ] feeling hot/cold	[ ] need to eat or tired	[ ] adrenal issues
[ ] chronic inflammation	[ ] parathyroid issues	[ ] type 1 diabetes	[ ] increased urination
[ ] autoimmune	[ ] thyroid issues	[ ] type 2 diabetes	[ ] hormone treatments

Please list any **ENDOCRINE Surgeries** and/or **Medications** with relevant dates and details

HEAD, EAR, NOSE, THROAT HISTORY [ ] No H.E.N.T. symptoms or conditions, surgeries, or medications.

[ ] saw ENT	[ ] dental issues	[ ] nose issues	[ ] swollen lymph nodes
[ ] saw physician	[ ] gum issues	[ ] sinus issues	[ ] TMJ problems
[ ] ear infections	[ ] eye problems	[ ] hearing issues	[ ] jaw clicking/pain
[ ] ear pain	[ ] glaucoma	[ ] ringing in ears	[ ] grinding teeth

Please list any **H.E.N.T. Surgeries** and/or **Medications** with relevant dates and details

MUSCULOSKELETAL HISTORY [ ] No reported musculoskeletal symptoms or conditions, surgeries, or medications.

[ ] saw physician	[ ] saw chiropractor	[ ] osteoarthritis	[ ] RA/ Autoimmune
[ ] saw orthopedist	[ ] saw phys. therap.	[ ] degenerative joints	[ ] chronic inflammation
[ ] saw pain mgt	[ ] saw acupuncturist	[ ] degenerative disc	[ ] osteoporosis/penia
[ ] saw rheumatologist	[ ] saw massage	[ ] fibromyalgia	[ ] bone issues

Please list any **MUSCULOSKELETAL Surgeries** and/or **Medications** with relevant dates and details

ADVANCED NEUROMUSCULOSKELETAL HISTORY

[ ] *Never had an X-ray*	[ ] *Never had an MRI*	[ ] History of CT-scan	*[ ] No history of injury*
[ ] Neck x-ray	[ ] Brain MRI	[ ] History of EMG	[ ] tendon strain/ tear
[ ] Thoracic x-ray	[ ] Neck MRI	[ ] History of Ultrasound	[ ] ligament Sprain/ Tear
[ ] Lumbar x-ray	[ ] Thoracic MRI	[ ] History of Injections	[ ] fracture/ dislocation
[ ] Shoulder x-ray	[ ] Lumbar MRI	[ ] History of Epidural	[ ] disc bulge/herniation
[ ] Hip x-ray	[ ] Shoulder MRI	[ ] History of Joint Surgery	[ ] history of weakness
[ ] Knee x-ray	[ ] Knee MRI	[ ] History Spine Surgery	[ ] history of numbness

Please add below **diagnosis**, **details**, and **dates** that you can remember.

Patient Name_____

PERSONAL HEALTH HISTORY

Check all boxes that apply

EATING HABITS

[ ] strictly controlled	[ ] 1 to 2 meals a day	[ ] no carb/cracker/cake/candy snacking
[ ] somewhat controlled	[ ] 2 to 3 meals a day	[ ] medium carb/cracker/cake/candy snacking
[ ] out of control and binge eating	[ ] 3 to 4 meals a day	[ ] heavy carb/cracker/cake/candy snacking
[ ] slow chewer	[ ] finish whole plate	[ ] late night eater
[ ] fast chewer	[ ] doesn't have to eat all	[ ] addicted to sugar

LIFESTYLE CHOICES

[ ] frequent exercise	[ ] alcohol daily	[ ] tobacco daily	[ ] history drug use	[ ] high caffeine
[ ] some exercise	[ ] some alcohol	[ ] some tobacco	[ ] current drug use	[ ] some caffeine
[ ] little/no exercise	[ ] little/no alcohol	[ ] little/no tobacco	[ ] no history drugs	[ ] little/no caffeine

SLEEP

[ ] strict sleeping habits	[ ] great sleep quality	[ ] wake up refreshed	[ ] snore
[ ] somewhat scheduled	[ ] okay sleep quality	[ ] wake up exhausted	[ ] toss and turn
[ ] no schedule to sleep	[ ] poor sleep quality	[ ] wake up in pain	[ ] nightly pain

MIND & SPIRIT

[ ] Happy	[ ] I have a clear purpose to my life - on track	[ ] meditate/ organized relaxation
[ ] OK	[ ] I think I have a purpose not sure - unsure	[ ] create time for myself - "escape"
[ ] Not Happy	[ ] I have no idea what I am doing - lost	[ ] no structured relaxation

SELF

[ ] I love myself	[ ] I understand why I am in pain	[ ] I take great care of myself
[ ] I do not love myself	[ ] My pain seems to be excessive	[ ] I sorta take care of myself
[ ] I don't like to think about it	[ ] My pain is unfair, cruel, and mysterious	[ ] I do not take care of myself

Is there a family history of any of the following? If so, indicate who it was (e.g. maternal grandfather, sister, etc)

[ ] STROKE [ ] CANCER [ ] HEART ATTACK [ ] DIABETES [ ] NEUROLOGICAL DISEASE

SIGNS OF INSULIN RESISTANCE	**SIGNS OF GUT STRESS**	**SIGNS OF ADRENAL DYSFUNCTION**
[ ] Feel tired after meal	[ ] Diarrhea/ Constipation	[ ] difficulty falling asleep
[ ] Still hungry after meal	[ ] Bloating/ Cramps	[ ] craving for salt/sugar
[ ] Tired if meal is missed	[ ] Headaches/ Brain Fog/ Memory	[ ] reliance on caffeine
[ ] Family history of diabetes	[ ] Migraines	[ ] increased energy at night
[ ] Family history high blood press.	[ ] Acne/ Eczema/ Rosacea	[ ] fatigue in morning
[ ] Central belly fat	[ ] Arthritis/ Joint Pain	[ ] intermittent crashes thru day
[ ] Craving for sweets/ carbs	[ ] Cravings for sweets/ carbs	**SIGNS OF VAGAL DYSFUNCTION**
[ ] Overweight	[ ] Food allergies/ sensitivities	[ ] chronic pain
[ ] Difficulty losing weight	[ ] Autoimmune/ Thyroid	[ ] fibromyalgia
[ ] Fatigue or weakness	[ ] Depression/ Anxiety	[ ] gas/bloating/constip/diarrhea
[ ] Mood swings/ irritability	[ ] Family history RA, Lupus	[ ] anxiety, panic, or depression
[ ] High cholesterol	[ ] Family history Crohn's/ Celiac	[ ] history of abuse