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: _____

MEDICAL HISTORY FORM

[ ] Hi exercise [ ] Lo exercise [ ] No exercise	[ ] Hi alcohol [ ] Lo alcohol [ ] No alcohol	[ ] Hi tobacco [ ] Lo tobacco [ ] No tobacco	[ ] Hi caffeine [ ] Lo caffeine [ ] No caffeine	[ ] great sleep [ ] okay sleep [ ] poor sleep	[ ] Happy [ ] OK [ ] Unhappy

HEART & LUNG HISTORY [ ] No reported cardiovascular symptoms or conditions, surgeries, or medications.

[ ] seen by physician [ ] surgeries/procedures [ ] medications	[ ] heart issues [ ] lung issues [ ] pacemaker	[ ] swollen legs or feet [ ] palpitations [ ] chest pain or tightness	[ ] shortness of breath [ ] asthma [ ] difficulty breathing

Details:

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

[ ] seen by physician [ ] surgeries/procedures [ ] medications [ ] neuro issues [ ] stroke/ TIA	[ ] neuropathy [ ] concussion [ ] tremors/shaking [ ] migraine [ ] seizures	**POSSIBLE SIGNS OF STROKE** [ ] severe headache [ ] difficulty swallowing [ ] slurred speech [ ] numb/tingling face/body	[ ] memory loss [ ] loss of sensation [ ] loss of balance/ dizzy [ ] weakness face/body [ ] changes in vision

Details:

MUSCULOSKELETAL HISTORY

[ ] saw orthopedist [ ] saw pain mgt [ ] saw rheumatologist	[ ] History of X-ray [ ] History of MRI [ ] History of CT-scan	[ ] muscle or tendon tear [ ] ligament injury [ ] fracture or dislocation	[ ] spinal procedure [ ] disc bulge/herniation [ ] other hospitalization

Details:

HEALTH ISSUES [ ] No reported gastrointestinal symptoms or conditions, surgeries, or medications.

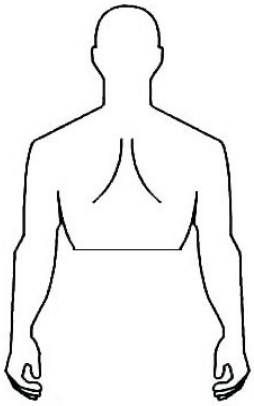
[ ] cancer [ ] autoimmune [ ] osteoarthritis [ ] arthritis/ rheumatism [ ] fibromyalgia	[ ] digestive issues [ ] abdominal pain [ ] infections [ ] illness or disease [ ] kidney stones	[ ] food sensitivities [ ] heartburn/ reflux [ ] skin issues [ ] hormonal issues [ ] chronic inflammation	[ ] changes in bowel habits [ ] changes in urination [ ] black/bloody stool [ ] osteoporosis/penia [ ] ear, nose, throat, eye

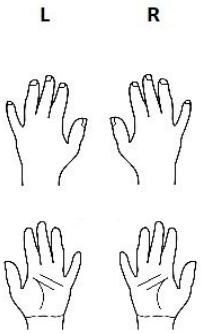
Details….Did we miss anything? Please feel free to add other information below

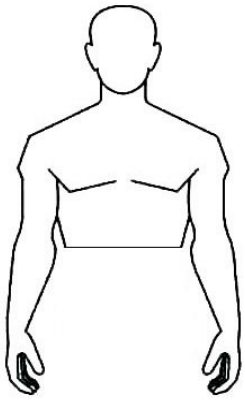
Is there a FAMILY HISTORY of any diseases like stroke, cancer, heart attack, diabetes, neurological disease, or other diseases? **[ ]None reported [ ]Yes, details below (e.g. "maternal grandfather heart attack"**

CHIEF COMPLAIN HISTORY Patient Name_____

UPPER REGION [ ]NO ISSUES IN THIS UPPER REGION [ ]IT'S AN OLD ISSUE [ ] IT'S A NEW ISSUE [ ]EXACERBATION
FEELS LIKE: [ ] PAIN [ ] ACHE [ ] STIFFNESS [ ] NUMBNESS [ ] BURNING [ ] TINGLING [ ] WEAKNESS







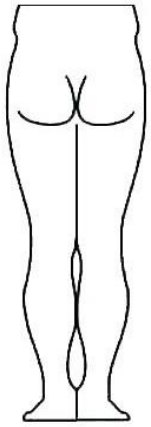
1- THIS PAIN WAS FIRST EVER EXPERIENCED:
[ ] YEARS AGO [ ] MONTHS AGO [ ] RECENTLY

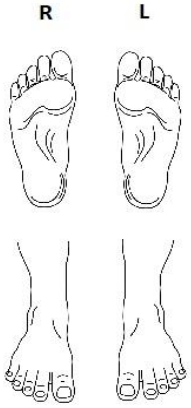
2- EST. DATE MOST RECENTLY WORSENED:

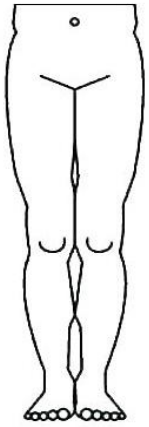
3- FACTORS THAT MAY HAVE CAUSED THIS:
[ ]Auto Accident [ ]Slip/ Fall [ ]Sports [ ]Exercise
[ ]Lifting Object [ ]Strenuous Job [ ]Computer Use
[ ]Poor Posture [ ]Injury [ ]Long commute/ Traveling
[ ]Housework [ ]Chores [ ]Standing [ ]Sitting
[ ]Intense Activities [ ]Physical stress [ ]Mental Stress

4- Please write below what may have caused this:

LOWER REGION [ ]NO ISSUES IN THIS UPPER REGION [ ]IT'S AN OLD ISSUE [ ] IT'S A NEW ISSUE [ ]EXACERBATION
FEELS LIKE: [ ] PAIN [ ] ACHE [ ] STIFFNESS [ ] NUMBNESS [ ] BURNING [ ] TINGLING [ ] WEAKNESS







1- THIS PAIN WAS FIRST EVER EXPERIENCED:
[ ] YEARS AGO [ ] MONTHS AGO [ ] RECENTLY

2- EST. DATE MOST RECENTLY WORSENED:

3- FACTORS THAT MAY HAVE CAUSED THIS:
[ ]Auto Accident [ ]Slip/ Fall [ ]Sports [ ]Exercise
[ ]Lifting Object [ ]Strenuous Job [ ]Computer Use
[ ]Poor Posture [ ]Injury [ ]Long commute/ Traveling
[ ]Housework [ ]Chores [ ]Standing [ ]Sitting
[ ]Intense Activities [ ]Physical stress [ ]Mental Stress

4- Please write below what may have caused this:

Activity	WORSENS	RELIEVES	SAME		Movement	WORSENS	RELIEVES	SAME
Walking					Twisting			
Sitting					Bending			
Standing					Extending			
Exercise					Lifting Objects			
Sleep					Cough/Sneeze			