(908) 617-5052

38 Main Street
High Bridge, NJ 08829

PERSONAL INFORMATION

PLEASE PRINT

First Name: _____ **M.I.**_____ **Last Name:**_____ **Preferred Name:**_____
Address: _____ **City:**_____ **State:**____ **Zip:**_____
Birthdate: ____/____/____ **Age:**_____ **Gender:** ☐**Female** ☐ **Male** ☐**Unspecified** **SSN:** ____/____/____
Primary Phone:_____ **Cell Phone:**_____ **Work Phone:** _____
Personal Email:_____ **Work Email:** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) ☐**Personal** ☐**Work**
Contact Method: (check one) ☐**Primary Phone** ☐**Cell Phone** ☐**Work Phone** ☐**Personal Email** ☐**Work Email**
Status: (check one) ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Separated** **Children?** ☐**Yes** ☐**No How many:**____
Spouse's Name: _____ **Multi-Racial** (check one) ☐**Yes** ☐**No** ☐**Unknown**
Race: ☐**White** ☐**Black/African American** ☐**Hispanic/Latino** ☐**Asian** ☐**Native American** ☐**Other** ☐**I choose not to specify**
Preferred Language: ☐**English** ☐**Spanish** ☐**French** ☐**Japanese** ☐**Chinese** ☐**German** ☐**Other** ☐**I choose not to specify**
Occupation:_____ **Employer:**_____
Emergency Contact: (Name, Relationship, Phone #) _____
Family Physician Name:_____ **City:**_____
How were you referred to Mind Over Matter Chiropractic? ☐**Patient**_____ ☐**Physician**_____
☐**Internet** ☐**Social Media** ☐**Friends** ☐**Family** ☐**Other:**_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to the receptionist.

Type of Insurance: ☐Private Ins. ☐Medicare ☐Auto Ins. ☐Worker's Comp ☐
Primary Insurance Carrier:_____ Phone:_____
Policy #:_____ Group #:_____ Claim #:_____
Name of Policy Holder:_____ Relationship to Patient:_____
Policy Holder's Birthdate:____/____/____ Policy Holder's SSN:____/___/_____ Employer:_____
Is the patient covered by another insurance? ☐Yes ☐No
Secondary Insurance Carrier:_____ Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Mind Over Matter Chiropractic and Wellness of High Bridge, NJ all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐**Private Pay/Cash:**By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X _____ **Date:**_____

Signature of Patient, Parent, or Legal Guardian (if minor)

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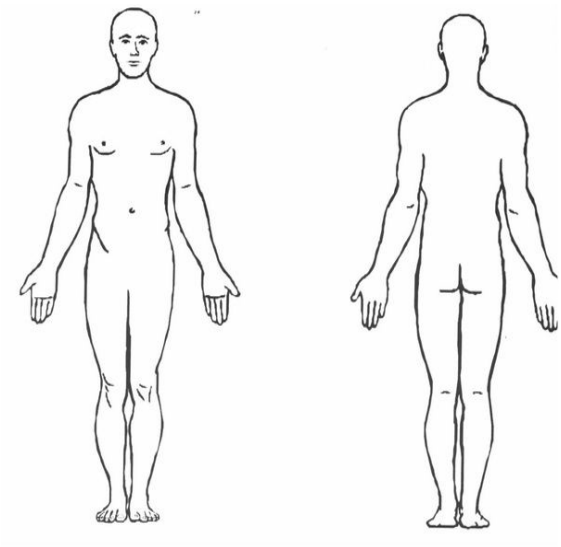
REASON FOR VISIT

What is the reason for your visit today? ☐Headache ☐Neck Pain ☐Mid-Back Pain ☐Low Back Pain ☐Other_____
What caused this complaint(s)? _____

_____

When did this complaint begin? ____/____/____ **Is it getting worse?** ☐Yes ☐No ☐Constant ☐Comes and goes
Have you had this or a similar complaint in the past? ☐Yes ☐No If "yes," when? _____

What does your complaint(s) feel like? Circle **all that apply:** *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other* _____



⇦ **Please** Circle **or mark an "X" on the body diagram to the left where you have pain or discomfort.**

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:
No Pain *Moderate Pain* *Worst Pain Possible*

1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shot, or travel to? (if applicable)?_____

What aggravates this complaint? Circle **all that apply:** *Sitting / Standing / Walking / Getting up from seat / Walking stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending forward / Bending downward / Twisting / Reaching / Lifting / Desk work / Sneezing / Coughing / Everything / Unknown / Other:*_____

What relieves this complaint? Circle **all that apply:** *Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Laying down / Meditation / Nothing / Unknown / Other:*_____
How often do you experience your symptoms? ☐25% of the day ☐50% of the day ☐75% of the day ☐100% of the day
Timing of complaint: Check appropriate box: ☐Morning ☐As day progresses ☐Afternoon ☐Evening ☐While sleeping ☐During activities ☐After activities ☐Symptoms are constant and do not change ☐Other:_____
With time are your symptoms: ☐Improving ☐Worsening ☐Not changing
Have you seen other doctors for this complaint? ☐Yes ☐No If "Yes," please provide the following information:
Doctor's name:_____ Date consulted:_____ Diagnosis:_____

Is this condition interfering with your: Circle **all that apply:** Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily Routine / Social Activities / Exercise / Other: _____
Is your complaining interfering with your daily activities? ☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

Name:_____ **Date:**_____

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HEALTH HISTORY

Please check **all** of the health conditions below that apply to **you** currently or in the past.		**Family History**- Mark **all** conditions that run in your family (Relationship: Father, Mother, Sister, Brother)
☐ Osteoarthritis/Degenerative Joint Disease	☐ Whiplash injury *Date of injury:*	☐ Cancer *Type:*
☐ Asthma	☐ Headaches	☐ Anemia
☐ Diabetes ☐ Type I ☐ Type II	☐ Joint Pain Circle location of pain: Shoulder, Elbow, Hip, Knee, Ankle, Other:_____	☐ Heart Problems / Stroke
☐ Anemia	☐ Migraines	☐ High Blood Pressure
☐ Cancer/Tumor	☐ Osteoporosis/Osteopenia	☐ Genetic Disorders
☐ Rheumatoid Arthritis	☐ Epilepsy / Seizures	Rheumatoid Arthritis
☐ Depression/Anxiety	☐ Fibromyalgia / Chronic Fatigue	☐ Other(list):
☐ Disc Herniation	☐ Genetic Disorders	
☐ High Blood Pressure/ Hypertension	☐ Please list any other medical conditions:	
☐ Heart Disease / Stroke		

Women Only: Currently Pregnant? ☐ Yes ☐ No **Painful/Abnormal Menstrual Cycle?** ☐ Yes ☐ No **Menopause?** ☐ Yes ☐ No

Miscarriage? ☐ Yes ☐ No **Do you have children?** ☐ Yes ☐ No **If "yes,"** type of birth? Circle Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date):

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No **Menopause?** ☐ Yes ☐ No

List current prescription medications, including frequency and dosage if known. If there are NO current medications, check here ☐

Name of prescription medication	Dosage/Start Date	*Name of prescription medication*	Dosage/Start Date
1.		4.	
2.		5.	
3.		6.	

List any known allergies you have had to prescription medications. If NO medication allergies are known, check here ☐

_____

_____

Name:_____ **Date:**_____

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MIND MATTER

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SOCIAL HISTORY

Height ft. in. **Weight:** lbs.
Do you exercise? ☐ Yes ☐ No **Times per week?** **Intensity:** ☐ Light ☐ Moderate ☐ Strenuous **Type?**
Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker If **"yes,"** how often do you smoke: ☐ Currently every day smoker ☐ Currently sometimes smoker If **"yes,"** what is your level of interest in quitting smoking? (0=NO interest, 10=Very interested) Circle **level below** ⇩ 0 1 2 3 4 5 6 7 8 9 10
Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** **For how many years?**
Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks
Do you take pain killers? ☐ Yes ☐ No **How often?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely **What type?** ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other:
What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:
Please describe your overall health right now? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
What is your current stress level? ☐ Mild ☐ Moderate ☐ High
Have you seen a chiropractor in the past? ☐ Yes ☐ No
What are your hobbies?

Name:_____ **Date:**_____

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INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," such as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

-Spinal manipulative therapy	-palpation	-vital signs	-range of motion testing
-Orthopedic testing	-basic neurological testing	-muscle strength testing	-postural analysis
-EMS	-ultrasound	-hot/cold therapy	-radiographic studies

-Other (please explain)_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1- Self-administered, over-the-counter analgesics and rest 2-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers 3-Hospitalization 4-Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE "BOX" AND SIGN BELOW:

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment.

I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Mind Over Matter Chiropractic & Wellness of High Bridge, NJ responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient's Name (Please Print) Doctor's Name (Please Print)

X _____ _____

Signature of Patient, Parent, or Legal Guardian (if a minor) Doctor's Signature