WELCOME TO OUR OFFICE!

Name ____ Cell Phone (_____)______-________

Address ____ Home Phone (_____)______-________

City, State, Zip Code ____________________________________ Birth Date ________________________

Social Security # ________-_______-___________ Age ________ Email _______________________________

Sex: ☐ Male ☐ Female If you are female, are you pregnant? ☐ No ☐ Yes

Who can we thank for referring you to our office? ☐ Chair Massage Event ___________________________
☐ Referred by ____ ☐ Internet ☐ Driving by

Occupation ______________________________ Employer _______________________________________

Spouse's Name _______________________________ Spouse's Employer ____________________________

Emergency Contact name and phone number _______________________________ (_____)_____-________

Please list any previous surgeries and the year performed:

____

____

What medication(s) are your currently taking and for what condition(s)?

____

____

Please list the year of any car accidents or hospitalizations:

____

____

If you have Health Insurance, what is the name and Birth Date of the Primary Insured? ☐ No Insurance
Name: ____ Date of Birth: _________________________

Please check-off any off these that apply to you:
☐ Arthritis ☐ Osteoporosis ☐ Anemia ☐ Diabetes ☐ Hepatitis ☐ Skin Problems
☐ Painful Sneezing or Coughing ☐ Stroke ☐ Fainting ☐ Tremors ☐ Muscle Weakness
☐ Smoke ☐ Drink Alcohol ☐ HIV/ AIDS ☐ Cancer: ______________________________________
Other/ further details: ____

Does anyone in your family have a history of:
☐ Headaches ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Cancer: ________________

Please UNDERLINE any Past Conditions and CIRCLE any Current Conditions.

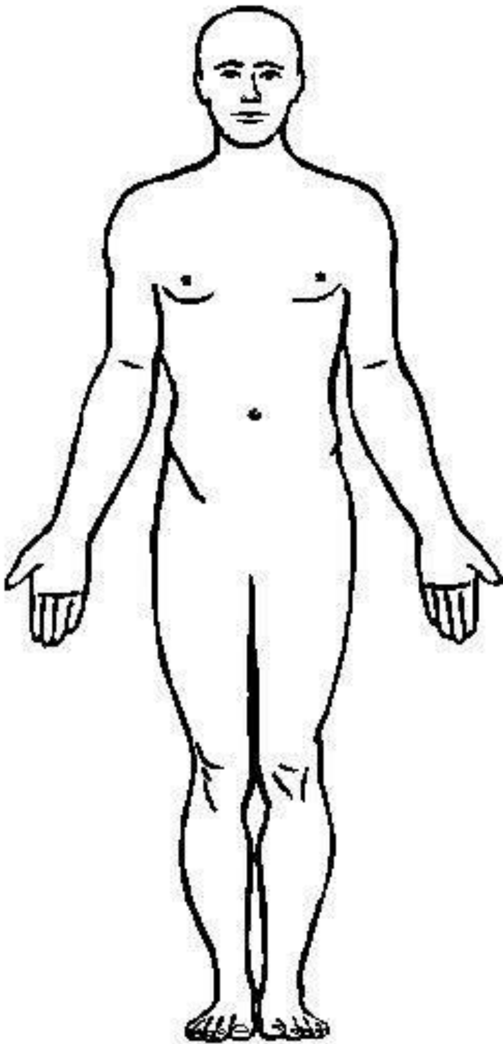
Level	Conditions
☐C1 ☐C2 ☐C3 ☐C4 ☐C5 ☐C6 ☐C7	●Neck Pain/ Stiffness ●Headaches/ Migraines ●Arm/Hand Numbness ●Carpal Tunnel ●Sinus Congestion ●Ear Infections ●Allergies ●Asthma ●Trouble Sleeping ●High Blood Pressure ●Low Blood Pressure ●High Cholesterol ●Depression ●Vision Problems ●Seizures/ Epilepsy ●Dizziness ●Fatigue ●Thyroid Condition
☐T1 ☐T2 ☐T3 ☐T4 ☐T5 ☐T6 ☐T7 ☐T8 ☐T9 ☐T10 ☐T11 ☐T12	●Mid-back Pain/ Stiffness ●Difficulty Breathing ●Chest Pain ●Shoulder Pain ●Shoulder Bursitis/ Tendonitis ●Bronchitis ●Pneumonia ●Heartburn ●Heart Condition ●Gastritis ●Ulcers ●Acid Reflux ●Lung/ Respiratory Problems ●Gallbladder Conditions ●Indigestion/ Upset Stomach ●Kidney Problems ●Liver Conditions ●Jaundice
☐L1 ☐L2 ☐L3 ☐L4 ☐L5 ☐RSI ☐Sacrum ☐Coccyx ☐LSI	●Low Back Pain/ Stiffness ●Back Spasms ●Sciatica ●Numbness/ Tingling in Legs or Feet ●Irritable Bowel Syndrome ●Constipation ●Diarrhea ●Bladder Problems ●Colitis ●Menstrual Problems ●Leg/ Foot Weakness

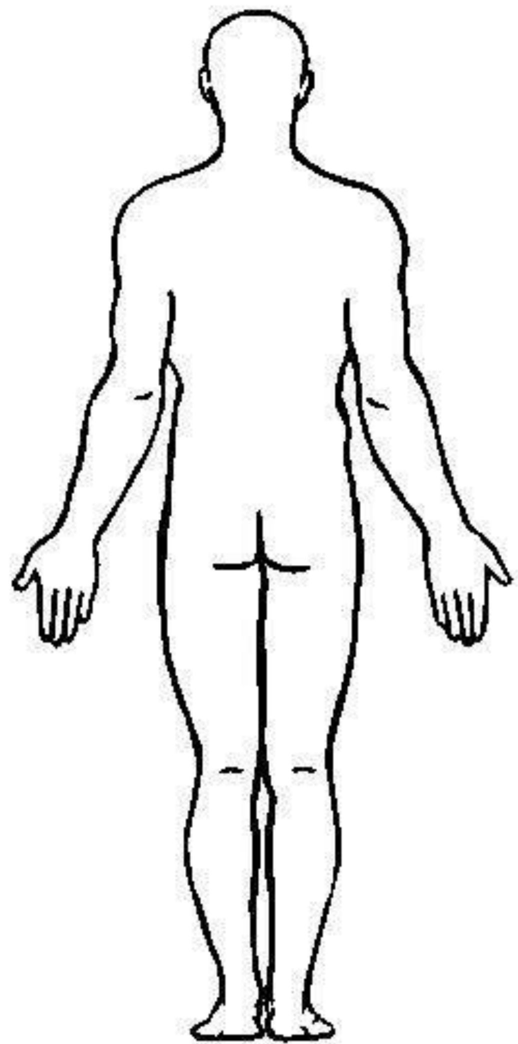
Pain Diagram

Please use the letters to indicate where all your discomfort is on the drawing below.

P = Pain	**A** = Achy	**B** = Burning
T = Tingling	**X** = Sharp-Shooting	**S** = Stiffness
N = Numbness		

Right Left Right





Health Status

Please place an "**X**" next to any Current conditions and a "**P**" next to any Past conditions

___ Neck Pain/ Stiffness ___ Mid-back Pain/ Stiffness ___ Low Back Pain/ Stiffness

___ Shoulder Pain ___ Elbow Pain ___ Pelvis/ Gluteus Pain

___ Hand/ Wrist Pain ___ Knee Pain ___ Hip Joint Pain

___ Ankle/ Foot Pain Other____

Which condition is your main concern? ____

How did it occur? ____

How long ago did this start? ____

It occurred: ☐ Suddenly ☐ Gradually

How would you describe it? ☐ Tight ☐ Deep ☐ Superficial ☐ Radiating ☐ Throbbing

On a scale from 1 to 10 (10 being the worst), how does it feel NOW? **1 2 3 4 5 6 7 8 9 10**

On a scale from 1 to 10, what is the WORST it has felt? **1 2 3 4 5 6 7 8 9 10**

Have you experienced this problem in the past? ________________________________

Is the problem getting: ☐ Worse ☐ Better ☐ Staying the same

Does the problem seem: ☐ Worse in morning ☐ Worse at night ☐ Worse after work
☐ No predictable pattern ☐ Constant ☐ On and off

What makes it worse? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Twisting
☐ Laying face-up ☐ Laying face-down ☐ Laying on side: ______________

What makes it better? ☐ Rest ☐ Ice ☐ Heat ☐ Massages ☐ Stretches
☐ Advil, Ibuprofen, Tylenol, Excedrin, etc. Other ______________________________

What previous treatments have you had in the past?
☐ Chiropractic ☐ Massage ☐ Physical Therapy ☐ Injections ☐ Surgery ☐ Acupuncture
Other ____

The above information is true and accurate to the best of my knowledge.

Patient Signature ______________________________ **Date**____________________

<u>Privacy Policy</u>

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. The privacy of your health information is important to us. We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information.

Uses and Disclosure of protected health information (PHI). We may use and disclose health information about your treatment, payment, and healthcare operations. For example:

A. Treatment: We will use and disclose your PHI to provide and coordinate your health care services with other authorized healthcare providers. Another example of this would be to use your PHI to make appointment reminders, send voice messages, letters, holiday/ birthday cards, etc.
B. Third Party Payors: Your PHI would be used as needed to obtain payment for your health care services. This may include communication with your health insurance company.
C. Business Associates: Whenever an agreement exists between an outside party and our office we will have a written contract that contains the terms that protect the privacy of your PHI.
D. Other Uses or Disclosures of PHI include: As required by law, for public health issues, for health oversight activities, to report blatant abuse, to report to the FDA as needed, for law enforcement purposes. Under the law, we must make certain disclosures when required to the secretary of health and human services Section 164.50 et.seq.
E. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse neglect, or domestic violence or a possible victim of other crimes, in an attempt to avert a serious threat to your health or safety or the health of safety of others.
F. We reserve the right to change the terms of our privacy policy at any time provided that the applicable law permits it, and will be in writing and made available to you upon request.

Your Rights:

A. You may obtain a copy of your PHI by making a request in writing, including the date it was made and the specific information you are requesting. Our office reserves the right to deny your request. If that is the case you will be notified of that decision in writing.
B. You have the right to request that this office restrict the use of your PHI. This office will attempt to accommodate reasonable requests.
C. You have the right to obtain a written copy of this policy upon request.
D. You have the right to file a complaint with us by writing: Privacy Officer, 15 Manchester Ave. Suite 8, Forked River, NJ 08731.

Other:

A. This office utilizes an “open treatment room” environment for ongoing patient care. In this environment patients are in earshot of other patients and staff. A private office is available for taking patient histories, performing examinations and presenting diagnostic results. The office is available any time for private consultation per the patient’s request.
B. This office reserves the right to use video and /or audio recording for the purposes of quality control and security.

Patient Name___________________________________ Date____________
Initials________