FREEDOM CHIROPRACTIC

Office: (856) 552-0570 Fax: (856) 988-1159
www.freedomchiropracticnj.com

Patient Information

Date: _____ Doctor: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Sex: M F Age: _____ Birth date: ____/____/_____

Single Married Widowed Separated Divorced

Occupation: _____

Employer: _____

Employer Phone: _____

Spouse's Name: _____

Whom may we thank for referring you?

_____

Phone Numbers

Home: _____

Work: _____

Cell: _____

Best time & place to reach you: _____

Insurance Information

Subscriber's Name: _____

Insurance Company: _____

Policy ID#: _____

Subscriber's Birth date: ____/____/_____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with (insurance company) _____ and assign directly to Freedom Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor(s) to release all information necessary to secure payment of bene- fits. I authorize the use of this signature on all insurance submissions.

_____

(Patient or Guardian's Signature) Date

Accident Information

Is your condition due to an accident? Yes No

If so, when did the accident happen? (Date) __/____/_____

Type of Accident: Auto Work Home Other

Have you reported your accident? Yes No

If so, to whom?:

Auto Insurance Employer Worker's Comp. Other

The patient understands and agrees to allow this chiropractic office to use his/her Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office. R.H.C. has my consent to use my name for the purpose of referral boards, testimonials, kids' photo boards, birthdays, etc. My name and/or photos will be used strictly for special acknowledgments.

Patient or Guardian's Signature: _____ Date: _____

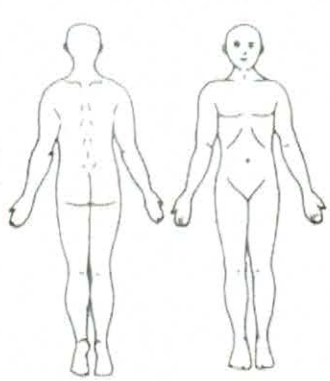
Patient Condition

Reason for visit: _____

When did your symptoms appear?: _____

How did it happen? _____

Describe the location of pain (mark on diagram): _____



Circle what best describes the pain: sharp spasms burning shooting throbbing

dull stiffness ache cramping tingling numbness swelling other: _____

Rate Severity (1-10, 10 is the worst)_____ **Is the pain getting worse?** Yes No

How long does the pain last? seconds minutes hours all day

How often does the pain occur? daily several times/week a.m. only p.m. only

Is the pain constant or does it come and go? (circle one) Constant Comes & Goes

What activities make the pain worse? sitting standing bending twisting lying down pushing pulling

driving getting out of a chair any movement walking other _____

What makes the pain feel better? rest activity ice heat massage stretching other: _____

Does the pain interfere with your..... work sleep daily routine recreation other: _____

Health History

Family Medical Doctor: _____ Phone Number: _____

What treatments have you already received for this condition?: Medications Surgery Physical Therapy Chiropractic Services None

Other: _____ Name & Address of other doctor(s) who have treated you for this condition: _____

Date of Last: Physical Exam: __/__/_____ Spinal X-ray: __/__/_____ Blood Test : __/__/_____ Spinal Exam: __/__/_____

Mammogram: __/__/_____ Chest X-ray: __/__/_____ Urine Test: __/__/_____ Dental X-ray: __/__/_____

MRI / CT / Bone / Dexa Scan: __/__/_____ Are you pregnant? No Yes Due Date : __/__/_____

Do you have (or have you ever had) the following?: (Please circle Yes or No)

AIDS/HIV	Yes No	Chicken Pox	Yes No	Kidney Disease	Yes No	Psychiatric Care	Yes No
Acid Reflux	Yes No	Diabetes	Yes No	Liver Disease	Yes No	Rheumatic Fever	Yes No
Alcoholism	Yes No	Emphysema	Yes No	Measles	Yes No	Rheumatoid Arthritis	Yes No
Allergies	Yes No	Epilepsy	Yes No	Migraines	Yes No	Scarlet Fever	Yes No
Anemia	Yes No	Fractures	Yes No	Miscarriage	Yes No	Stroke	Yes No
Anorexia	Yes No	Glaucoma	Yes No	Mononucleosis	Yes No	Suicide Attempt	Yes No
Appendicitis	Yes No	Goiter	Yes No	Multiple Sclerosis	Yes No	Thyroid Problems	Yes No
Arthritis	Yes No	Gonorrhea	Yes No	Mumps	Yes No	Tonsillitis	Yes No
Asthma	Yes No	Gout	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Bleeding Disorder	Yes No	Heart Disease	Yes No	Pacemaker	Yes No	Tumors / Growths	Yes No
Breast Lump	Yes No	Hepatitis	Yes No	Parkinson's Disease	Yes No	Typhoid Fever	Yes No
Bronchitis	Yes No	Hernia	Yes No	Pinched Nerve	Yes No	Ulcers	Yes No
Bulimia	Yes No	Herniated Disc	Yes No	Pneumonia	Yes No	Venereal Disease	Yes No
Cancer	Yes No	Herpes	Yes No	Polio	Yes No	Whooping Cough	Yes No
Cataracts	Yes No	High Blood Pressure	Yes No	Prostate Problem	Yes No		
Chemical Dependency	Yes No	High Cholesterol	Yes No	Prosthesis	Yes No		

Other Illnesses?: _____

Family Medical History: Mother: _____ Father: _____

Siblings: _____ Grandparents: _____ Other: _____

Complicated Factors: _____

Exercise:

How many times a week? _____

Type: _____

Work Activity:

Hours / week: _____

Sitting Light Labor

Standing Heavy Labor

Habits:

Smoking: Packs per Day ____

Alcohol: Drinks per Week __

Sleep Position _____

Coffee/Caffeine: Cups per Day __

High Stress Level: Reason _____

How old is your mattress? _____

Injuries / Surgeries you have had:

	Description	Date
Car Accidents 1.	_____	/___/___
2.	_____	/___/___
Falls (down stairs, on ice, etc.):	_____	/___/___
Head Injuries / Concussions:	_____	/___/___
Broken Bones:	_____	/___/___
Dislocations:	_____	/___/___
Surgeries / Hospitalizations:	_____	/___/___

Medications

_____

_____

Allergies

_____

_____

Vitamins / Herbs / Minerals

_____

_____

Doctor's Signature: _____ Date: ____/____/__

Vaccination History (Circle/check off all that apply)

Did you choose to vaccinate your child? **Yes** **No**
If yes, please check all vaccinations received: **DPT** **MMR** **Polio** **Chicken Pox** **Hepatitis** **Flu**
Other_____ Please describe your child's reaction to these vaccines: _____
_____

Growth and Development
Was the child breastfed? _____ How long?_____ Any difficulties?_____
At what age was formula introduced? _____ Type:_____ Cow's Milk?_____ Solid Foods?_____
Has your child had antibiotics? **No** **Yes** If yes, which ones and why? _____

At what age did the child:
Respond to sound?_____ Follow an object?_____ Hold up head?_____ Sit unassisted?_____
Crawl?_____ Vocalize?_____ Teethe?_____ Walk?_____

Has your child ever had any of the following?

- ☐ Headaches
- ☐ Dizziness
- ☐ Allergies
- ☐ Ear Problems
- ☐ Eye Problems
- ☐ Sleeping disorders
- ☐ Breathing Problems
- ☐ Fatigue
- ☐ Irritability
- ☐ Hyperactivity
- ☐ Frequent Colds
- ☐ Flu
- ☐ Bloody Noses
- ☐ Asthma
- ☐ Meningitis
- ☐ Diarrhea
- ☐ Constipation
- ☐ Colic
- ☐ Rashes
- ☐ Food Intolerances
- ☐ Bed wetting
- ☐ Digestive Problems
- ☐ Poor Posture
- ☐ Learning Disorders
- ☐ Seizures/convulsions
- ☐ Heart trouble
- ☐ Joint problems
- ☐ Scoliosis
- ☐ Anemia
- ☐ Hypertension
- ☐ Broken bones
- ☐ Muscular problems

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (changing table, bed, high chair, etc.) Was this the case with your child? **Yes** **No**

Has your child ever....
Fallen from heights over 2 feet? **Yes** **No**
Been in a motor vehicle accident? **Yes** **No**
Suffered a sports injury? **Yes** **No**
Been hospitalized? **Yes** **No**
Suffered a brain injury? **Yes** **No**
Played high impact or contact sports? **Yes** **No**
Suffered any trauma not listed above?_____

Is your child accident-prone? **Yes** **No** Any pets in the home? **Yes** **No** Smokers in the home? **Yes** **No**

Physical Activity and Childhood Nutrition
Approximate # of hours of physical activity/ play time each week:_____
# of hours of TV/computer each week:_____
Does your child carry a backpack? _____ Approximate weight of backpack:_____
Does your child consume: **Caffeine** **Soda** **Sugar** **Artificial Sweeteners** **Fast Food** **Processed Food**
If applicable, has your child experienced menstruation? **Yes** **No** Age at onset? _____