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: _____

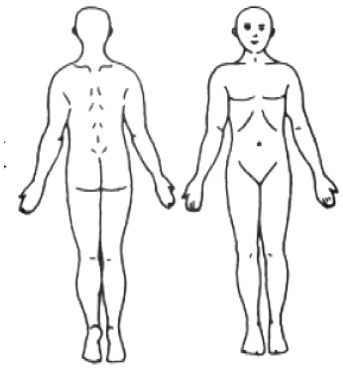
Patient Condition

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: ____/_____/__