Schooley's Mountain CHIROPRACTIC

CONFIDENTIAL PATIENT CASE HISTORY

SCHOOLEY'S MOUNTAIN CHIROPRACTIC CENTER

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you, and if so how long your expected recovery may take. If we do not sincerely believe that your condition will respond satisfactorily we will not accept your case, and will attempt to make an appropriate referral for you. **THANK YOU** for your consideration and time in filling out this paperwork.

Today's Date _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Telephone (____) ____-_____ Work Telephone (____) ____-_____

Cell Phone (____) ____-_____ E-Mail _____

If from out of town please provide local address and telephone number.

Address _____ City _____ State _____ Zip _____

Telephone Number (____) ____-_____

Age _____ Birth Date ____/____/____ Marital Status S M W D How many children _____

Occupation _____ Employer _____

Work Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse's Office Telephone (____) ____-_____

Nearest Relative & Telephone Number _____(____)____-_____

Who referred you to our office? _____

HEALTH INFORMATION

What is Your Major Complaint? _____

_____

Other complaints: _____

How long have you had this condition?

❑ Greater than 8 days ❑ Less than 6 weeks ❑ Greater than 6 weeks ❑ Greater than 16 weeks

Have you had this or a similar condition in the past? _____ How many episodes? ❑ less than 3 ❑ greater than 3

Describe the severity of your condition ❑ mild ❑ moderate ❑ severe ❑ crippling ❑ bedridden

To the best of your knowledge is this injury superimposed on any pre-existing structural or skeletal anomaly that you know of? _____

Is your present condition ❑ Getting better ❑ Getting worse ❑ Staying the same ❑ Coming and going

What activities aggravate your condition? _____

What provides you relief for this condition? _____

List your primary care doctor or any other doctors that you have consulted or sought treatment with for this condition:

Name _____ Specialty _____

Address _____ Telephone number _____

Name _____ Specialty _____

Address _____ Telephone number _____

PAST HEALTH HISTORY

What surgeries have you had and/or fractures (broken bones), etc.
Type/When/Doctor/Remarks _____

_____

Have you been in an auto accident? _____ ❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never
Describe: What/When/Symptoms/Treatment/Results _____

_____

Have you had any other serious accidents injuries and/or falls(work, personal injury, home, sports, leisure, other)? _____
❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never
Describe: What/When/ Symptoms/Treatment/Results _____

_____

OCCUPATIONAL (Please circle all appropriate answers)

Type of work station: Seated / Standing Workbench / Desk Counter / Other

Job involves – Lifting (how much : Light Medium Heavy) Bending / Stooping / Twisting / Turning / Carrying /Walking / Standing / Other

Type of chair – Executive / Steno / Bench / Stool / Folding / Other _____

Shoe style – High heels / Dress shoes / Work boots / Sneakers / Loafers / Other _____

Do any of your work activities aggravate your present main complaint? (Describe) _____

DO YOU HAVE A PERMANENT IMPAIRMENT / DISABILITY RATING? _____

Location _____ Date received _____ Rating Percentage _____

COMMENTS: _____

LEISURE
Sedentary activities – TV/Reading/Card games/Sewing/Computer/Other (circle all applicable & describe how long)

_____

Strenuous activities – Sports/exercise (type, frequency, length of time) Have you had to discontinue any activities? _____

Describe _____

How would you describe your general stress level? ❑None ❑Minimal ❑Moderate ❑High ❑Greatly Stressed

Physical activity at work ❑sedentary greater than 50% of day ❑sedentary less than 50% of day
❑light manual labor ❑manual labor ❑heavy labor

General physical activity ❑ no regular program ❑ light exercise ❑ medium exercise ❑ heavy exercise Program

Coffee, tea, caffeinated soft drinks (cups per day) _____ Tobacco (packs per day) _____

Please circle current conditions —check former conditions

GENERAL SYMPTOMS
- ❑ Headache
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Gain/Loss of Weight
- ❑ Numbness/pain in arms, hands, legs, feet
- ❑ Allergy
- ❑ Wheezing
- ❑ Neuralgia/neuritis
- ❑ Depression

E.E.N.T.
- ❑ Failing vision
- ❑ Near sightedness
- ❑ Far sightedness
- ❑ Crossed eyes
- ❑ Eye pain
- ❑ Deafness
- ❑ Earache
- ❑ Ear discharge
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Hoarseness
- ❑ Hay fever

E.E.N.T. continued
- ❑ Tinnitus
- ❑ Asthma
- ❑ Gum trouble
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Tonsillitis
- ❑ Sinus infection
- ❑ Nasal drainage
- ❑ Enlarged glands

SKIN
- ❑ Skin eruptions
- ❑ Itching
- ❑ Bruise easily
- ❑ Dryness
- ❑ Boils
- ❑ Varicose veins
- ❑ Sensitive skin
- ❑ Hive or allergy

RESPIRATORY
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficulty breathing

CARDIO VASCULAR
- ❑ Rapid beating heart
- ❑ High blood pressure
- ❑ Low blood pressure

CARDIOVASCULAR continued
- ❑ Pain over heart
- ❑ Previous heart attack
- ❑ Hardening of the arteries
- ❑ Swelling of the ankles
- ❑ Poor circulation
- ❑ Paralytic stroke
- ❑ Aneurysm

MUSCLE & JOINT
- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Pain in shoulders
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture
- ❑ Arthritis

GENITOURINARY
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Bed wetting
- ❑ Inability to control urine

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Difficult digestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting of blood
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Colon trouble
- ❑ Hemorrhoids (piles)
- ❑ Intestinal worms
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis

FOR WOMEN ONLY
- ❑ Painful menstruation
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Congested breast
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Pregnancy

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?
- ❑ Appendicitis
- ❑ Scarlet fever
- ❑ Diphtheria
- ❑ Typhoid fever
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Polio
- ❑ Malaria
- ❑ Tuberculosis
- ❑ Whooping cough
- ❑ Anemia
- ❑ Measles
- ❑ Mumps
- ❑ Small pox
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart disease
- ❑ Goiter
- ❑ Influenza
- ❑ Pleurisy
- ❑ Alcoholism
- ❑ Venereal infection
- ❑ Epilepsy
- ❑ Mental disorder
- ❑ Eczema
- ❑ Drug dependency
- ❑ Emphysema
- ❑ Asthma

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

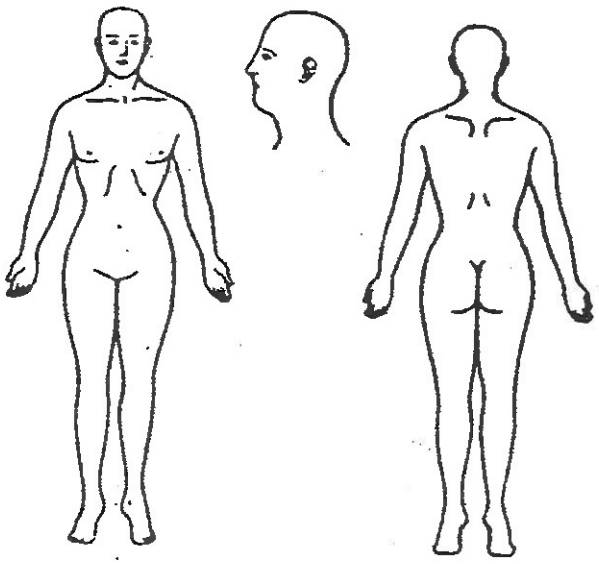
Signed: _____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary to my child.

Signed: _____ (Parent / Legal Guardian)

Date of your last physical examination _____

Please mark and grade your areas of pain on the figures and scale below



Extreme 10
*
*
*
*
5
*
*
*
*
Absent 0

INSURANCE INFORMATION

Is your condition due to an automobile accident or a job related injury? ❑ Yes ❑ No

If this is a work related injury do you have authorization to treat in this office? ❑ Yes ❑ No

If this is an automobile accident related have you reported this to your insurance carrier? ❑ Yes ❑ No

Do you have health insurance? ❑ Yes ❑ No If yes,

Name of Company _____ Policy # _____ Effective date ____/____/____.

Are you covered by Medicare? ❑ Yes ❑ No If yes, Health Insurance # _____

Name of Company providing your medicare coverage _____ Effective date ____/____/____.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. In this age of managed care I acknowledge that verification that coverage does exist does not guarantee that payment will be made. Furthermore I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in full of all charges.

I consent to examination and treatment by the doctors of this office. And I acknowledge my responsibility for payment of all charges, even those that my insurance carrier (PPO, POS, or HMO) may not deem medically necessary but that this Chiropractic Office in the best interest of the patient does. (i.e. Examinations, Radiographic Evaluation, Chiropractic Spinal Adjustments, Adjunctive Therapy or Other Services)

I also understand that if I suspend care and treatment, any fees for professional services rendered me will be immediately due and payable.

I will be paying today by: ❑ Cash ❑ Check ❑ Visa ❑ MC ❑ AmEx

Card Number # _____ CVV # _____ Exp. Date _____

All accounts not paid within 90 days will be charged 1.5% on the outstanding balanced and automatically put through on your credit card.

Patient's Signature _____ Date ____/____/____

Guardian or Spouse's Signature _____ Soc. Sec.# _____

Doctor's Signature _____ Date ____/____/____

FAMILY HEALTH INFORMATION (Many health problems are the result of heredity weaknesses; thus information about your family members will give us a better picture of your total health picture.)

Name	Relation	Past and Present Health Problems

There are three types of care: Relief Care which will temporarily ease your systems or Corrective Care that will solve the problem.
At this time I prefer ❑ Relief Care ❑ Corrective Care ❑ Wellness Care

Schooley's Mountain
CHIROPRACTIC
Your Health in Our Hands
484 Schooley's Mountain Rd | Hackettstown, NJ 07840
o 908-852-6752 | f 908-852-5903

Date: _____ File #: _____

Dear Patient,

In order to better serve you, we are asking you to please take a couple of moments to complete the following information. Please print clearly.

Name: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail address: _____

Should the need arise to contact you; what is the best time of day to reach you?
_____a.m. / p.m.

What of the above numbers is best to try first, second and third….

1._____

2._____

3._____

If you are unavailable by phone, do you prefer us to send an e-mail or a text message?

_____

Thank you. We will keep our attempts to reach you to a minimum. Yet, should the need arise, we want to make sure we are able to get back in contact with you as quickly as possible.

Sincerely,

Jeffrey M. Culbert, D.C., C.C.S.P.

Schooley's Mountain CHIROPRACTIC

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During the course of your care as a patient at Schooley's Mountain Chiropractic Center, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein.

We are also required to provide you with this notice of our privacy practices with respect to your health information.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible. Any change in our privacy notice will apply for all your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Ms. Luanne Culbert.
If you would like further information about our privacy policies and practices, please contact Ms. Luanne Culbert.

This notice is effective as of the date of your signature below. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____
Name (Print) Signature Date

If you are a minor or are represented by another party:

_____ _____ _____
Personal Representation (Print) Signature Date

THE BELOW IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

I give my authorization to use or disclose my protected health information as described. I give this authorization voluntarily.

Patient's Name:_____

Address: _____

Phone Number: _____

Name the person(s) that you are authorizing to use and or disclose the protected health information (if you do not want your information disclosed to anyone, please write 'No One' on the line below):

Person 1 Name _____ Phone number_____ Relation _____	Person 2 Name _____ Phone number_____ Relation _____

CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the privacy officer at the office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people named above.

Patient Signature: _____ Date:_____

Print Name: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.