1one Welcome

ABOUT YOU

Today's Date: _____ File #:_____

Patient Name: _____
Last First MI

What do you prefer to be called? _____ _Male _Female
Birth date: ___/___/____ Age: ____ SS#: _____
Mailing address: _____

_____
City State Zip

Home phone: _____
Work phone: _____
Cell phone: _____
E-mail address: _____
Referred By: _____
Employer: _____
Employer's address: _____

_____
City State Zip

Occupation: _____
Status: _Minor _Single _Married _Divorced _Separated _Widowed
Spouse's name: _____
Do you have children? __Yes __ No How many? ___

2two INSURANCE INFO

Co. Name: _____
Address: _____

_____
City State Zip

Phone #: _____
Insured's SS#: _____
Group #: _____
Insured's Name: _____
Relation: _____
Insured's DOB: ____/____/_____
Insured's Employer: _____

_____

Please inform front desk of 2nd insurance source

3three REASON FOR VISIT

The reason for this visit is a result of (*Please Circle*): work, sports, auto, trauma, or chronic
(Explain what happened): _____

_____

Please describe the pain & it's location: _____

_____

When did condition begin? ____/_____/_____
Is this condition getting worse? __Yes __No __Constant __Comes and goes
Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine
If so, please explain: _____
Have you ever had this or similar conditions in the past? ___Yes ___No
If s, please explain: _____
Have you ever been treated by a Medical Physician for this condition?
___Yes ___No
If so, where? _____
Have you ever been treated by a chiropractor before? __Yes __ No
If so, whom? _____ Phone #:_____

four

IN EVENT OF EMERGENCY

Who should we contact?_____
Relation: _____
Home phone #: _____ Work #_____
Who is your medical doctor? _____ Phone #:_____

HEALTH HISTORY

five

six

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart murmur
Y N Congenital Heart Defect	Y N Mirtal Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Dusease	Y N Hepatitis
Y N HIV+/Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/ Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/ Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition(s) you have/had:

_____

Please list anything that you may be allergic to: _____

_____

List any **past** serious accidents with dates:_____

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ☐Yes ☐No / Exercise? __
Are you on a special diet: ☐ Yes ☐ No / Since: ____/____/_____
Do you smoke? ☐ Yes ☐ No / How Much? _____ How long? ___
What is the age of your mattress? ____ Is it comfortable? ☐Yes ☐No
Are you wearing ☐Heel lifts ☐Sole lifts ☐Inner Soles ☐ Arch Support
For women: Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ No ☐ Yes/How long? ___ Nursing? ☐ Yes ☐ No

ACCOUNT INFO

Person ultimately responsible for account

Name: _____
Relation: _____
Billing Address: _____

_____

SSN: _____
D.L.# _____
Work Phone: _____
Payment Method:
☐Cash ☐ Check ☐ Credit

_____
Credit Card-Enter card # above

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance co. (I offered at this office)

- We invite you to discuss with us any questions regarding our services. The best health based on a friendly, mutual understanding between provider and patient.
- Our policy requires payments in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days if the date if service and no financial arrangements have been made, you will responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/____/_____

BODY CHART

REASON FOR VISIT

Name: _____ Date: ___/___/___ File #: _____

What is your current weight:_____ lbs., and height,_____Ft._____In..

Reason for visit: ❑ Work Accident ❑ Sports Injury ❑ Car Accident ❑ Trauma/Injury ❑ Chronic Pain ❑ Routine Adjustment

Explain what happened:_____

When did condition begin?___/___/___ Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine Have you had this or similar conditions in the past? ❑ Yes ❑ No

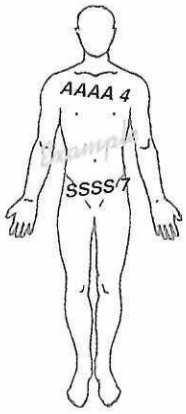
If so, please explain:_____

SHOW US WHERE IT HURTS

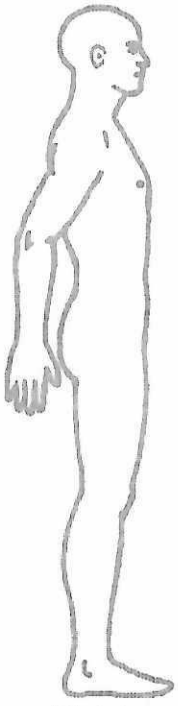
Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

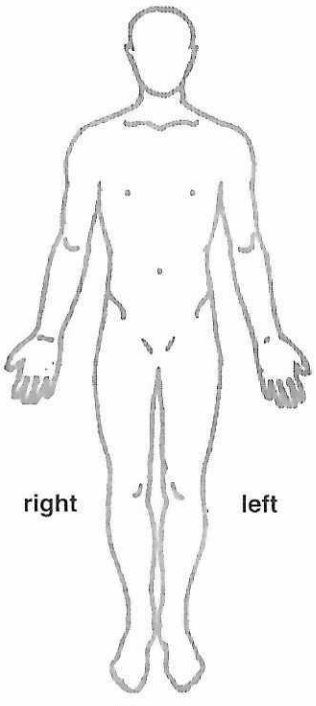
◯ Circle any area of pain not represented by a symbol.



Example

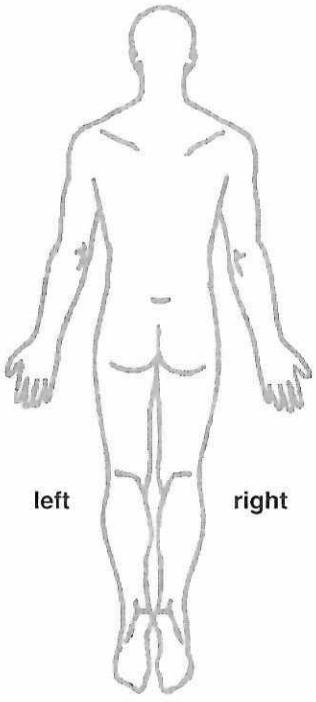


Right



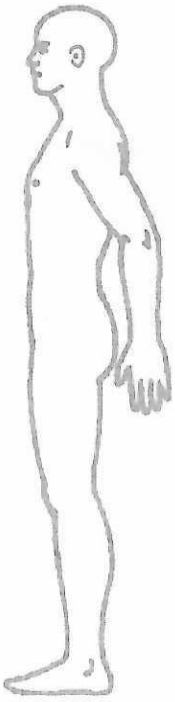
right left

Front



left right

Back



Left

DOCTOR'S NOTES

_____

_____

_____

_____

_____

Grossman Chiropractic & Physical Therapy

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

I understand that the treatment I receive at this clinic is from a licensed and credentialed Doctor of Chiropractic. Chiropractic scope of practice includes a wide range of services, if upon completion of a differential diagnosis and assessment of patient condition, it is determined the services required are not provided by this office, we will direct you to the appropriate health care provider.

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Spinal manipulation is done to ease pain and help the body function better. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the potential risks:**

- Temporary soreness or increased symptoms or pain It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- Dizziness, nausea, flushing These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.
- Fractures When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed, and your treatment plan will be modified to minimize risk of fracture.
- Disc herniation or prolapse Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.
- Stroke A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both Doctors of Chiropractic and primary care medical doctors before or during their stroke.
- Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- Bruising Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

Alternatives to manipulation discussed through a shared decision-making process include: Medicines, Physical therapy, Massage, Mobilization, Acupuncture, and/or Cognitive-behavioral therapy. You can do these whether or not you are doing spinal manipulation. **Refusing Care** may carry a risk to future capabilities in regard to performing activities of daily living or progression towards chronic pain.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. The material risks have been disclosed to me, including a description of those material risks; and after consideration, I agree to the procedures understanding any material risks which are inherent to that procedure

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• PATIENT PLEASE REVIEW • PRINT & SIGN NAME •

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print)_____ **DATE OF BIRTH**_____

_____ _____ _____ _____

(PATIENT SIGNATURE) **(DATE)** **(TRANSLATOR | INTERPRETER SIGNATURE)** **(DATE)**

CLINICIAN ONLY

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

□ OF LEGAL AGE □ APPEARS UNIMPAIRED □ CONSENT GIVEN THROUGH GUARDIAN
□ ORIENTED X3 □ FLUENT IN ENGLISH □ ASSISTED BY A TRANSLATOR OR INTERPRETER

_____, **D.C.** _____

(D.C. SIGNATURE) **(DATE)**

Grossman Chiropractic & Physical Therapy

South Brunswick
397 Ridge Rd. STE 2
Dayton, NJ 08810
(732) 438-8700

Highland Park
1001 Raritan Ave.
Highland Park, NJ 08904
(732) 572-2225

Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Grossman Chiropractic & Physical Therapy, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date