WellnessOne™ of South Bergen

FAMILY CHIROPRACTIC CENTER
Physical Therapy
Massage Therapy
Acupuncture
Nutritional Counseling

Acupuncture Appointments

1. Please bring your new patient questionnaire, filled out, with you to your first appointment.
2. Please bring or wear loose clothing (shorts, t-shirts) to each appointment.
3. Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.

What to expect at your first visit?

Your first visit will take approximately one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you may have prior to treatment. I will come up with a diagnosis, a treatment plan and a few suggestions regarding your condition.

Marcus Rosario, LAc.

186 Paterson Avenue East Rutherford, NJ 07073 | Phone: (201) 933-3040 | Fax: (201) 933-8611
www.wellness1ofsb.com | E-mail: famchiroer@gmail.com | Find us on Facebook www.facebook.com/wellness1fcc

ACUPUNCTURE: WHAT IS IT?

Acupuncture is a method of encouraging the body to promote natural healing and to improve functioning. This is done by inserting needles and applying heat or electrical stimulation at very precise acupuncture points.

HOW DOES ACUPUNCTURE WORK?

The classical Chinese explanation is that channels of energy run in regular patterns through the body and over its surface. These energy channels, called meridians, are like rivers flowing through the body to irrigate and nourish the tissues. An obstruction in the movement of these energy rivers is like a dam that backs up in others.

The meridians can be influenced by needling the acupuncture points; the acupuncture needles unblock the obstructions at the dams, and reestablish the regular flow through the meridians. Acupuncture treatments can therefore help the body's internal organs to correct imbalances in their digestion, absorption, and energy production activities, and in the circulation of their energy through the meridians.

The modern scientific explanation is that needling the acupuncture points stimulates the nervous system to release chemicals in the muscles, spinal cord, and brain. These chemicals will either change the experience of pain, or they will trigger the release of other chemicals and hormones which influence the body's own internal regulating system.

The improved energy and biochemical balance produced by acupuncture results in stimulating the body's natural healing abilities, and in promoting physical and emotional well-being.

WHAT IS THE SCOPE OF MEDICAL ACUPUNCTURE?

Medical acupuncture is a system which can influence three areas of health care:

- **promotion of health and well-being,**
- **prevention of illness,**
- **treatment of various medical conditions.**

While acupuncture is often associated with pain control, in the hands of a well-trained practitioner it has much broader applications. Acupuncture can be effective as the only treatment used, or as the support or adjunct to other medial treatment forms in many medical and surgical disorders.The **World Health Organization** recognizes the use of acupuncture in the treatment of a wide range of medical problems, including:

- **Digestive disorders:** gastritis and hyperacidity, spastic colon, constipation, diarrhea.
- **Respiratory disorders:** sinusitis, sore throat, bronchitis, asthma, recurrent chest infections.
- **Neurological and muscular disorders:** headaches, facial tics, neck pain, rib neuritis, frozen shoulder, tennis elbow, various forms of tendinitis, low back pain, sciatica, osteoarthritis.
- **Urinary, menstrual, and reproductive problems.**

Acupuncture is particularly useful in resolving physical problems related to **tension** and **stress** and **emotional conditions**.

Wellness 1 of South Bergen™

Elliot P. Foster. D.C., PA • David G. Foster, D.C. • & Associates
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HEALTH QUESTIONNAIRE

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

NAME (LAST, FIRST)	COMPLETE ADDRESS (INCLUDE CITY, STATE & ZIP CODE)	DATE

E-MAIL ADDRESS: *Your e-mail will NOT be shared with any 3rd parties, and is used for occasional office announcements and information.	CELL PHONE Would you allow us to text you appointment confirmation? ☐ YES ☐ NO	DATE OF BIRTH AGE
WOULD YOU LIKE TO RECEIVE OUR E-MAILS: ☐ YES ☐ NO	HOME PHONE	

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	___ NO. OF CHILDREN	SOCIAL SECURITY NUMBER

EMPLOYER:	OCCUPATION	PRIMARY CARE DR	PRIMARY DR. PHONE #

HOW DID YOU HEAR ABOUT US?:	HAVE YOU HAD CHIROPRACTIC CARE BEFORE? YES NO WHERE?

DO YOU HAVE HEALTH INSURANCE?
☐ YES ☐ NO COMPANY POLICY# GROUP#

DO YOU HAVE SECONDARY HEALTH INSURANCE?
☐YES ☐ NO COMPANY POLICY# GROUP#

PRIMARY INS. HOLDER'S NAME:	DATE OF BIRTH	SECONDARY INS. HOLDER'S NAME:	DATE OF BIRTH

WHERE DO YOU FEEL THE PROBLEM?	WHAT IS YOUR MAJOR COMPLAINT?
HOW LONG HAS IT BEEN BOTHERING YOU?	HAS IT BOTHERED YOU BEFORE?

Have you ever had any falls, auto accidents, or injuries: ☐ Yes ☐ No	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

Do you take any:	VITAMINS	DRUGS	HERBS
Dosage:			

✓ Please check any of the following that give you difficulty.

- ☐ Headaches
- ☐ Shooting head pains
- ☐ Sinus trouble
- ☐ Loss of smell
- ☐ Allergies
- ☐ Hay fever
- ☐ Asthma
- ☐ Loss of taste
- ☐ Inflammation of throat
- ☐ Thyroid trouble
- ☐ Nerves & nervousness Inner tension
- ☐ Irritability
- ☐ Gall bladder trouble
- ☐ Indigestion
- ☐ Intestinal gas
- ☐ Twitching of face
- ☐ Loss of memory
- ☐ Fatigue
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Lights bother eyes
- ☐ Low back pain
- ☐ Ulcers
- ☐ Numbness legs or feet
- ☐ Constipation
- ☐ Kidney trouble
- ☐ Menstrual irregularity
- ☐ Neck pain
- ☐ Muscle spasms in neck
- ☐ Grinding in neck
- ☐ Tightness of shoulders & arms
- ☐ Pain in shoulders & arms
- ☐ Pins & needles in arms & hands
- ☐ Cold hands
- ☐ Numbness in arms/hands
- ☐ Menstrual cramps and pain
- ☐ Diabetes
- ☐ Cancer
- ☐ Sleeping problems
- ☐ Painful joints
- ☐ Cold hands/fingers
- ☐ Shortness of breath
- ☐ Mid-back pain
- ☐ Heart attacks
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Stomach trouble
- ☐ Swollen joints
- ☐ Pins & needles in legs
- ☐ Swollen ankles
- ☐ Cold feet

ASSIGNMENT OF BENEFITS:

I _____ fully understand that I am directly and fully responsible to said doctors for all bills for services rendered.

I hereby authorize my insurance company to pay directly to Wellness One of South Bergen the benefits allowable and otherwise payable to my under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agreed to pay in a current manner any balance if said professional service charges are over and above this insurance payment. It is understood and agreed that the amount paid for x-rays is for examination only and the x-ray negatives will remain property of this office, being on the file where they may be seen at any time while a patient of this office.

_____ _____ _____

Print Patient's Name Signature Date

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT & HEALTHCARE OPERATION

I consent to the use or disclosure of my protected health information by Wellness One/Family Chiropractic Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the Wellness One/Family Chiropractic Center. I understand that diagnosis or treatment of me by the doctors of Wellness One/Family Chiropractic Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Wellness One/Family Chiropractic Center is not required to agree to the restrictions that I may request. However, If Wellness One/Family Chiropractic Center agrees to a restriction that I request, the restriction is binding on Wellness One/Family Chiropractic Center and its doctors.

I have the right to revoke this consent in writing, at any time, except to the extent that the doctors of Wellness One/Family Chiropractic Centers have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wellness One/Family Chiropractic Center's Notice of Privacy Practices prior to signing this document. The Wellness One/Family Chiropractic Center's Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operation of Wellness One/Family Chiropractic Center. The Notice of Privacy Practices for Wellness One/Family Chiropractic Center is also provided on the wall in the waiting area and on Wellness One/Family Chiropractic Center's website at www.wellness1ofsb.com. This Notice of Privacy Practices also describes my rights and the Wellness One/Family Chiropractic Center's duty with respect to my protected health information.

Wellness One/Family Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Wellness One/Family Chiropractic Center's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____ _____

Print Patient's Name Signature Date

WellnessOne™ of South Bergen

Family Chiropractic Center™

Name:_____ _____ _____ Date:_____
Last First M.I.

DOB:_____ Sex: □M □F Occupation: _____

General Information:

State your main complaint or illness:_____

When did it begin?:_____ What causes it?:_____

What have you done to try to remedy this problem?:_____

_____

Have you ever been hospitalized?: □Yes □No Surgery?: □Yes □No Describe:_____

_____

Do you have a Pacemaker?: □Yes □No Please list all medications/conditions, vitamins/herbs you take or any food allergies:

_____

_____

_____

Please list any diet restrictions or preferences:_____

_____

_____

Please check any frequent use of the following:

□Alcohol □coffee □tea □ tobacco □ salt □sugar □over the counter medications.

Please check any injuries and indicate location:

□Fracture □ dislocations □sprain □concussion/head injury □loss of consciousness

_____

_____

Please check if any apply:

PERSONAL HISTORY

□Heart Disease
□Hay Fever
□Rheumatic Fever
□Epilepsy
□Cancer
□Mental Disorder
□Kidney Disease
□Hypertension
□Polio
□Bladder Disease
□Gallbladder Disease
□Boils/Infection
□Anemia
□Pneumonia
□AIDS
□Meningitis
□Rectal Disease
□Nervous Breakdown
□Miscarriage
□Alcoholism
□Hepatitis
□TB
□Diabetes
□Asthma
□Syphilis
□Gonorrhea
□Pleurisy
□Drug Abuse
□IBS
□Fibromyalgia
□Other

FAMILY HISTORY

□Cancer
□Headache
□Allergies
□Stroke
□Ulcers
□Hypertension
□Asthma
□Alcoholism
□ Diabetes
□Glaucoma
□Mental Disorder
□Heart Disease
□TB
□ Drug Abuse
□ Kidney Disease
□Epilepsy
□Other

Please indicate when valid the duration, frequency, location and intensity 1-10 pain scale for each condition you may have circled.

GENERAL SYMPTOMS

- □ Tremors
- □ Headache
- □ Fever
- □ Sweats
- □ Fainting
- □ Dizziness
- □ Convulsions
- □ Insomnia
- □ Fatigue
- □ Nervousness
- □ Depression
- □ Loss of weight
- □ Forgetfulness
- □ Confusion
- □ Numbness/Pain
- □ Paralysis

EYES, EARS, NOSE AND THROAT

- □ Blurred Vision
- □ Eye pain
- □ Eye strain
- □ Eye congestion
- □ Cross eyed
- □ Glaucoma
- □ Deafness
- □ Ear pain or stuffy
- □ Ear discharge
- □ Ear noises (tinnitus)
- □ Nose bleeds
- □ Nasal drainage
- □ Sinus infection
- □ Sore throat
- □ Hoarseness
- □ Difficult speech
- □ Difficulty swallowing
- □ Loss of taste
- □ Dental decay
- □ Gum troubles
- □ Tonsillitis
- □ Enlarged thyroid
- □ Enlarged glands
- □ Nasal obstruction
- □ Loss of smell
- □ Allergies

SKIN

- □ Skin eruptions
- □ Clammy skin
- □ Dryness
- □ Bruises easily
- □ Boils
- □ Rashes
- □ Sensitive skin
- □ Hives
- □ Allergy

GASTROINTESTINAL

- □ Poor appetite
- □ Excessive Hunger
- □ Bloating
- □ Belching
- □ Nausea
- □ Gas
- □ Vomiting
- □ Vomiting of blood
- □ Gastric Pain
- □ Distention of abdomen
- □ Constipation
- □ Diarrhea
- □ Black stool
- □ Blood in stool
- □ Hemorrhoids
- □ Parasite
- □ Pain in the ribs/hypochondria
- □ Gall Bladder stone
- □ Jaundice
- □ Overweight
- □Underweight

URINARY

- □ Frequent urination
- □ Scanty urine
- □ Painful urination
- □ Blood in urine
- □ Foul smelling urine
- □ Discolored urine
- □ Pus in urine
- □ Kidney infection or stones
- □ Bed wetting
- □ Inability to control urine
- □ Prostate trouble

MUSCLE AND JOINT

- □ Bone spur
- □ Foot trouble
- □ Herniated disc
- □ Lower back pain
- □ Spinal scoliosis
- □ Faulty posture
- □ Swollen joints
- □ Stiff joints
- □ Painful joints
- □ Sore muscles
- □ Weak muscles
- □ Walking problems
- □ Sciatica

MALE

- □ Pain in genitals
- □ Reduced sexual activity
- □ Premature ejaculation
- □ Seminal emission
- □ Impotence
- □ Discharge

FEMALE

- □ PMS
- □ Painful menstrual cycle
- □ Excessive flow
- □ Irregular cycle
- □ Cramps or back pain
- □ Previous miscarriage
- □ Vaginal discharge
- □ Vaginal pain
- □ Lumps in breast
- □ Congested breast
- □ Breast pain
- □ Reduced sexual activity
- □ Menopausal symptoms
- □ Hot flashes
- □ Abnormal bleeding
- □ Pregnancy complications

BODY TEMPERATURE

- □ Tend to run cold
- □ Tend to run hot

Please Print Name:_____ Patient Signature:_____

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Pain Chart

Pain Representation

Ache
V V V V V V V
V V V V V V

Burning
= = = = = = =
= = = = =

Numbness
O O O O O O O O O
O O O O O O O

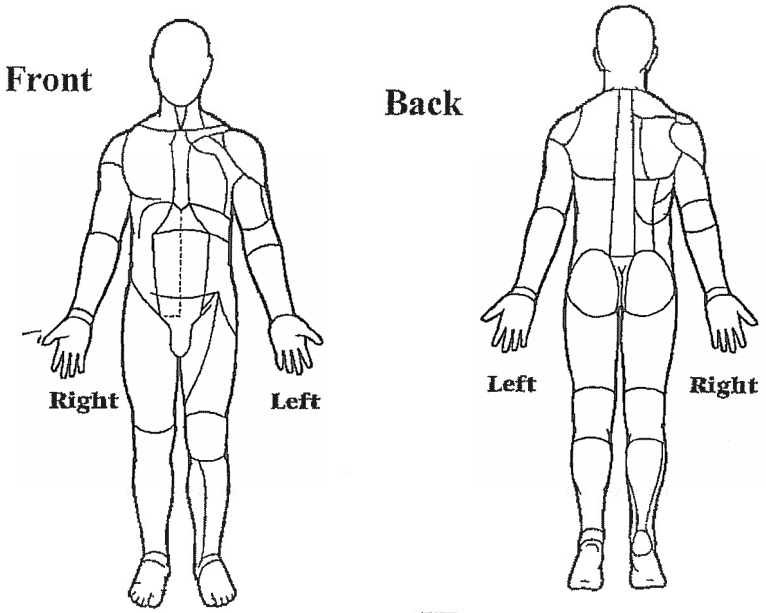
Pins & Needles
● ● ● ● ● ● ●
● ● ● ● ● ●

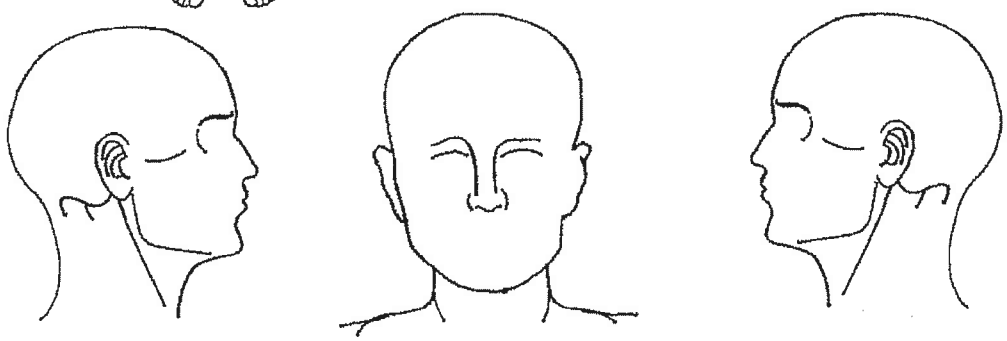
Stabbing
/ / / / / / / / /
/ / / / / / / /

Other
X X X X X X X
X X X X X X

Patient's Name _____

Draw location and type of pain on the body and head outline and mark the degree on the pain line at the bottom of the page.





No Pain **Worst Pain Possible**

Please make a slash through this line to indicate the level of your pain.

Patient's /Guardian's Signature _____ Date _____

WellnessOne™ of South Bergen

FAMILY CHIROPRACTIC CENTER

Chiropractic

Physical Therapy

Massage Therapy

Acupuncture

ACUPUNCTURE CONSENT FORM

"Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation by means of apparatus or instrument), the moxibustion (the therapeutic of an acupuncture point or points on or near the surface of the body use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

I also understand that treatment of Oriental Medicine may include adjunctive therapies alongside with Acupuncture treatments, such as cupping, Gua Sha, Tui Na (Asian Bodywork Therapy), Qigong exercises, and dietary and lifestyle advice (from a Chinese Medical prospective).

The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea and aggravation of problematic symptoms existing prior to acupuncture symptoms.

The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for medications or other invasive therapies, and improves the balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

Please Note: The acupuncture treatment (which includes procedures described above) that you will receive today and in the future at Wellness One of South Bergen will be carried out by Marcus Rosario, L.Ac. LMBT (Licensed Acupuncturist and Licensed Massage and Bodywork Therapist) who is qualified to practice and perform acupuncture treatments in the State of New Jersey.

"With this knowledge, I voluntarily consent to the above procedures."

_____ _____

Patient's Printed Name Patient Signature

_____ _____

Witness (Practitioner) Date

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WellnessOne™ of South Bergen

Family Chiropractic Center™

WELLNESS ONE
FAMILY CHIROPRACTIC CENTER
PRIVACY POLICY

The privacy of your information is important to Wellness One/Family Chiropractic Center. We have implemented policies that protect any personal data from improper use and alteration.

We have placed appropriate physical, electronic and managerial procedures in place to safeguard any breach of privacy. Our policies comply or exceed with all Federal HIPAA regulations.

The information we collect will be used to offer superior healthcare in addition to communications and questions that will inform And enhance the healthy chiropractic lifestyle.

I consent to receive information that Wellness One/Family Chiropractic Center offers me. This information could be in a written handout, electronic communication, or verbal suggestion. I am in no way obligated to follow any suggestions that are offered by the office, I understand that the suggestions are purely recommendations.

Print Name:_____

Signature:_____

Date:_____

WellnessOne™ of South Bergen

FAMILY CHIROPRACTIC CENTER

Physical Therapy
Massage Therapy
Acupuncture
Nutritional Counseling

Missed Appointment Policy

Everyone here at Wellness One of South Bergen is striving to provide the best care possible. The staff at Wellness One embraces the opportunity to provide an office that is prompt, clean, effective and efficient. In order to provide the best possible results, our patients must also strive to engage their responsibility to be prompt, and thorough in completing their treatment plan.

Since there are limited numbers of appointment times available, we expect the common courtesy to arrive on time and follow through with the recommended number of visits. With the exception of serious emergencies it is expected that you will keep your appointments and complete your care plan. Our friendly office staff will confirm your appointment date and time at least 24 hours prior to your appointment.

If you need to reschedule your appointment, we request a 24 hour notice to do so. Currently Wellness One has hours **Monday, Tuesday, Wednesday, Thursday,** and **Friday** from the morning until early evening.

In the even t of a no-show for a scheduled appointment or less then the 24 hour notice, we reserve the right to charge a $25 no show fee.

We appreciate your partnership in offering the finest care available.

_____ _____

Please Print Name Patient signature

_____ _____

Witness Today's Date

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