CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____
_____
_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer – Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

FAMILY MEDICAL HISTORY:

Mother: Age: _____ ( ) Living ( ) Deceased
Father: Age: _____ ( ) Living ( ) Deceased
Siblings: Age: _____ ( ) Living ( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer – Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis

□ Ulcer □ Varicose Veins □ Other: _____

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other:_____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: _____

EYES: □ Eye strain □ Wear glasses or contact lenses □ Sensitivity to light

EAR, NOSE,THROAT □ Ringing in ears □ Hearing loss □ Discharge or pain □ Dizziness
□ Runny nose □ Difficulty breathing through nose □ Sinusitis
□ Painful teeth, gums, or palate □ Growths in the mouth
□ Pain or difficulty swallowing □ Hoarseness

CARDIOVASCULAR □ Palpitations □ Chest pain □ Fainting □ Dizziness
□ Varicose veins □ Difficulty climbing Stairs □ Pain in the legs

	□ Cold Feet/Hands		□ Shortness of breath	
RESPIRATORY	□ Shortness of breath while walking		□ Cough with or without phlegm	
	□ Asthma/Wheezing		□ Spit up blood	
	□ Other: _____			
GASTROINTESTINAL	□ Abdominal pain	□ Nausea	□ Vomiting	□ Diarrhea
	□ Hemorrhoids	□ Change in shape or color of stool		
GENITOURINARY	□ Discharge	□ Pain	□ Frequent urination	□ Pain with urination
MUSCULOSKELETAL	□ Weakness	□ Back Pain	□ Neck Pain	□ Leg Pain
	□ Arm Pain	□ Shoulder Pain	□ Numbness	□ Headaches
	□ Other: _____			
SKIN	□ Jaundice	□ Dry skin	□ Pigment Change	□ Growths
	□ Moles that have changed color, shape, or bleed			
NEUROLOGIC	□Tremors	□ Weakness	□ Numbness	□ Memory Loss
	□ Confusion	□ Other: _____		

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Brunswick Chiropractic Center of New Jersey, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Brunswick Chiropractic Center of New Jersey, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Brunswick Chiropractic Center of New Jersey, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Brunswick Chiropractic Center of New Jersey, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

Registration Form

Please complete this form, print it out and bring to your appointment.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:

DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____

AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY # _____

EMPLOYER: _____ ☐ FULL TIME ☐ PART TIME

ADDRESS: _____

WORK PHONE: _____ E-MAIL: _____

OCCUPATION: _____ DRIVERS LIC. #: _____

How did your hear about our office? _____

SPOUSE/EMERGENCY CONTACT: _____

ADDRESS: _____ HOME PHONE: _____

RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

PRIMARY MD NAME: _____ PHONE #: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT –LIST MOTOR VEHICLE INS. FIRST)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SEC. INSURANCE)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

Check If Applicable: ☐Motor Vehicle Accident ☐ Work Injury Date of Accident: _____