*Family Chiropractors of Montclair*
*39 Watchung Plaza - Montclair, NJ 07042*
*(973) 783-5666*

# New Patient Form

Today's Date: _____

## Personal Information

Patient Name: _____ Date of Birth: _____/_____/_____ Sex: Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Mobile Phone: (_____)_____-_____

Email: _____ Employer: _____

Age: _____ Height: _____'_____" Weight: _____ Blood Pressure: _____/_____

**Preferred Language:** ☐ English ☐ Other: _____

Have you ever been to a Chiropractor before? Y / N

## Health Insurance Information

Insurance Carrier: _____ Patient ID #: _____

Name of Primary Card Holder: _____ Primary Card Holder Sex: Male / Female

Relation to Patient: _____ Primary Card Holder D.O.B: _____/_____/_____

# of Members on Plan: _____

**Ethnicity:** ☐ Hispanic or Latino
☐ NOT Hispanic or Latino

**Marital Status:** ☐ Single
☐ Married
☐ Divorced

**Race:** ☐ White
☐ Black / African American
☐ Asian
☐ American Indian / Alaskan Native
☐ Native Hawaiian / Pacific Islander
☐ Other: _____

**Smoking Status:** ☐ Smoke Every Day
☐ Smoke Some Days
☐ Former Smoker
☐ Never Smoked

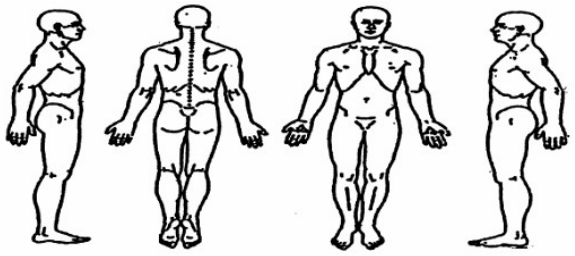
**For confidential correspondence, please create a secret question and answer**
**ie. What was your first pet's name? Fido:**

Question: _____ Answer: _____

## Please tell us the reason for your visit: Wellness or Main Complaint?



1. Indicate on the drawings below where you have pain / symptoms:



2. Please check off the location(s) of your problem, and circle "L" for Left, "R" for Right:

| | | | |
|---|---|---|---|
| ☐ Head | ☐ Shoulder (L / R) | ☐ Hand (L / R) | ☐ Leg (L / R) |
| ☐ Jaw | ☐ Arm (L / R) | ☐ Mid Back | ☐ Knee (L / R) |
| ☐ Neck | ☐ Elbow (L / R) | ☐ Low Back | ☐ Ankle (L / R) |
| ☐ Upper Back | ☐ Wrist (L / R) | ☐ Hip (L / R) | ☐ Foot (L / R) |

3. How would you describe the type of pain?

| | | | |
|---|---|---|---|
| ☐ Sharp | ☐ Burning | ☐ Tingly | ☐ Electric w/ motion |
| ☐ Dull | ☐ Shooting | ☐ Sharp w/ motion | ☐ Other: _____ |
| ☐ Diffuse | ☐ Stiff | ☐ Shooting w/ motion | |
| ☐ Achy | ☐ Numb | ☐ Stabbing w/ motion | |

4. How often do you experience these symptoms?

| | |
|---|---|
| ☐ Constantly (76 – 100% of the time) | ☐ Frequently (51 – 75% of the time) |
| ☐ Occasionally (26 – 50% of the time) | ☐ Intermittently (1 – 25% of the time) |

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 1 to 10, (10 being the worst), how would you rate your problem? (Please circle one)

1 2 3 4 5 6 7 8 9 10

7. How long have you had this problem? _____ Day(s) / Month(s) / Year(s)

8. How do you think your problem began?

_____

9. What aggravates your problem?

| | | | |
|---|---|---|---|
| ☐ Always There | ☐ Standing | ☐ Sitting | ☐ Climbing Stairs |
| ☐ Bending | ☐ Lifting | ☐ Carrying | ☐ Picking Up Child |
| ☐ Reaching | ☐ Pulling | ☐ Pushing | ☐ Deep Breaths |
| ☐ Coughing | ☐ Sneezing | ☐ Sleeping | ☐ Turning Over in Bed |
| ☐ Bathing | ☐ Dressing | ☐ Driving | ☐ Household Chores |
| ☐ Gardening | ☐ Shoveling | ☐ Stress | ☐ Weather Change |
| ☐ Traveling | ☐ Work | ☐ Computer | ☐ Playing a Sport: _____ |
| ☐ Exercising: _____ | | ☐ Physical Work: _____ | |

10. Who else have you seen for this problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Massage Therapist
☐ Physical Therapist ☐ No One ☐ Other: _____

11. What is your occupation?

☐ Laborer ☐ Teacher ☐ Trader ☐ Tradesperson
☐ Truck Driver ☐ Student ☐ Homemaker ☐ Professional / Executive
☐ Retired ☐ Unemployed ☐ Disabled ☐ Other: _____

12. What do you do at work / throughout your day (check all that apply)?

**Sit →** ☐ Most of the day ☐ Half of the day ☐ Some of the day
**Stand →** ☐ Most of the day ☐ Half of the day ☐ Some of the day
**Computer →** ☐ Most of the day ☐ Half of the day ☐ Some of the day
**Drive →** ☐ Most of the day ☐ Half of the day ☐ Some of the day
**On The Phone →** ☐ Most of the day ☐ Half of the day ☐ Some of the day
☐ Manual Labor ☐ Read a lot ☐ Travels Frequently

13. How much does your problem interfered with your work or daily routine?

☐ Not at all ☐ A Little Bit ☐ Moderately
☐ Quite a Bit ☐ Extremely

14. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good
☐ Fair ☐ Poor

15. What kind of regular exercise do you perform?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

16. What type of recreational activity do you do?

☐ Aerobics ☐ Play Basketball ☐ Play Baseball
☐ Bicycle ☐ Play Football ☐ Play Golf
☐ Hike ☐ Play Ice Hockey ☐ Inline Skate
☐ Jog ☐ Martial Arts ☐ Rock Climb
☐ Ski ☐ Play Soccer ☐ Play Softball
☐ Swim ☐ Play Tennis ☐ Triathlons
☐ Play Volleyball ☐ Walk ☐ Lift Weights
☐ Work Out ☐ Yoga ☐ Other: _____

17. Have you ever been hospitalized? ☐Yes ☐No

If yes, please explain: _____

18. Have you had significant trauma or surgery in the past ? ☐Yes ☐No

If yes, please explain: _____

19. **Family History** – Please check all that apply of the following (Select "M" for Mother; "F" for Father):

☐ Rheumatoid Arthritis M / F ☐ Diabetes M / F ☐ Lupus M / F
☐ Heart Disease M / F ☐ Cancer M / F ☐ ALS M / F

20. **Your History** – Please indicate below what conditions you have had both in the past and present:

| Past | Present | | Past | Present | | Past | Present | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Headaches | ☐ | ☐ | Asthma | ☐ | ☐ | Muscular Incoordination |
| ☐ | ☐ | Neck Pain | ☐ | ☐ | Chronic Sinusitis | ☐ | ☐ | Visual Disturbances |
| ☐ | ☐ | Upper Back Pain | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Dizziness |
| ☐ | ☐ | Mid Back Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Diabetes |
| ☐ | ☐ | Low Back Pain | ☐ | ☐ | Chest Pains | ☐ | ☐ | Excessive Thirst |
| ☐ | ☐ | Shoulder Pain | ☐ | ☐ | Stroke | ☐ | ☐ | Frequent Urination |
| ☐ | ☐ | Elbow / Upper Arm Pain | ☐ | ☐ | Angina | ☐ | ☐ | Smoking / Tobacco Use |
| ☐ | ☐ | Wrist Pain | ☐ | ☐ | Kidney Stones | ☐ | ☐ | Drug / Alcohol Dependence |
| ☐ | ☐ | Hand Pain | ☐ | ☐ | Kidney Disorders | ☐ | ☐ | Allergies |
| ☐ | ☐ | Hip Pain | ☐ | ☐ | Bladder Infection | ☐ | ☐ | Depression |
| ☐ | ☐ | Upper Leg Pain | ☐ | ☐ | Painful Urination | ☐ | ☐ | Systemic Lupus |
| ☐ | ☐ | Knee Pain | ☐ | ☐ | Loss of Bladder Control | ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Lower Leg Pain | ☐ | ☐ | Prostate Problems | ☐ | ☐ | Dermatitis / Eczema / Rash |
| ☐ | ☐ | Ankle / Foot Pain | ☐ | ☐ | Abnormal Weight Gain / Loss | ☐ | ☐ | HIV / AIDS |
| ☐ | ☐ | Jaw Pain | ☐ | ☐ | Loss of Appetite | ☐ | ☐ | Other: _____ |
| ☐ | ☐ | Joint Pain / Stiffness | ☐ | ☐ | Abdominal Pain | | | |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Ulcer | | | **For Females Only:** |
| ☐ | ☐ | Rheumatoid Arthritis | ☐ | ☐ | Hepatitis | ☐ | ☐ | Birth Control Pills |
| ☐ | ☐ | Cancer | ☐ | ☐ | Liver / Gall Bladder Disorder | ☐ | ☐ | Hormonal Replacement |
| ☐ | ☐ | Tumor | ☐ | ☐ | General Fatigue | ☐ | ☐ | Pregnancy |

21. **Medications** – Please list all Prescription Medications you are currently taking below:
Check here if you are not taking any mediations:☐

| **Medication:** ie. Lipitor | **# of MD Refills Issued:** | **Quantity of Pills per Refill:** | **Strength:** ie. 10 mg | **Dose Form:** ie. Caspsule | **MD's Instructions:** ie. 1 per day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

22. **Medications** – Please list all Medications you are allergic to:

Check here if you do not have any allergies:☐

| **Name of Medication:** ie. Penicillin | **Reaction:** ie. Rash and Headache |
|---|---|
| | |
| | |

23. Is there anything else pertinent to your visit today you would like us to know?

_____

24. Have you had an Influenza Vaccination this year? Y / N

25. Whom may we thank for your referral? ☺ _____

## PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FAMILY CHIROPRACTORS OF MONTCLAIR IS PERMITTED BY LAW, TO USE MY PERSONAL HEALTH INFORMATION, TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FAMILY CHIROPRACTORS OF MONTCLAIR HAS AGREED TO ASSIST ME IN BILLING, MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES, AND ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE, FOR ALL FEES I INCUR IN CONNECTION WITH SERVICE RENDERED FOR THE PURPOSE OF TODAY'S ENCOUNTER, AS WELL AS ANY FUTURE SERVICES, FOR ANY CONDITIONS, KNOWN OR AS OF YET UNKNOWN.

**I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FAMILY CHIROPRACTORS OF MONTCLAIR TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATE'S STATUTES.**

**Patient Signature**_____ **Date:**_____

## STATEMENT OF NON-ACCIDENT

I, _____, am currently receiving chiropractic care at this facility. Please know that this care is **not related** to any auto accident, worker's compensation injury, or any other type of injury in which there is a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact me personally.

_____ _____

Print Name Signature

# COORDINATION OF BENEFITS STATEMENT

**Do you have a Secondary Insurance?** (circle one) **YES** **NO**
Name of Secondary Insurance Company_____

Name of Policy Holder: _____ Policy ID #:_____

_____ _____
Print Name Signature

## HIPPA FORM

We are required by State and Federal Law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the rights 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 following the changes. Any change in our privacy notice will apply for all of 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:**

Dr. Luis Mizraji. Privacy Officer
If you would like further information about our privacy policies and practices, please contact:

**Dr. Luis Mizraji. Privacy Officer**
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.
This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here to will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_____ _____ _____
Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

_____ _____ _____
Personal Representative (please print) Personal Representative Signature Date