Family Chiropractic Center of Bayonne

Noah De Koyer, D.C.
120 Lefante Way ● Bayonne ● New Jersey ● 07002
Phone (201) 437-0033 ● Fax (201) 858-4049
www.fccofbayonne.com

HEALTH QUESTIONNAIRE

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

LAST NAME	FIRST NAME	M.I.	E-MAIL ADDRESS	DATE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	ALT. PHONE	DATE OF BIRTH	AGE

EMPLOYER	OCCUPATION	SOCIAL SECURITY NUMBER

☐ MARRIED ☐ SINGLE NO. OF CHILDREN
☐ DIVORCED ☐ WIDOWED

REFERRED BY:

Have YOU had CHIROPRACTIC CARE BEFORE? YES or NO *(Please Circle)*
If So: WHERE? HOW LONG AGO?

Do YOU have HEALTH INSURANCE? YES or NO *(Please Circle)*
Company: Policy # Group#

PLEASE INDICATE IF YOU ARE HERE BECAUSE OF AN:
☐ Auto Accident ☐ On the Job Injury

IF SO: Date of Injury

WHAT IS YOUR MAJOR COMPLAINT?

HOW LONG HAS IT BEEN BOTHERING YOU?	HAS IT BOTHERED YOU BEFORE?	HOW LONG AGO?

(1-6) PAST HISTORY HAVE YOU HAD ANY FALLS, AUTO ACCIDENTS, INJURIES, OR SURGERIES? *IF YES, PLEASE DESCRIBE IN BOXES TO THE RIGHT*	MONTH/YEAR INJURY OR SURGERY	TYPE OF INJURY/SURGERY	DESCRIBE INJURY

DO YOU TAKE ANY?	TYPE AND DOSES
(7) PRESCRIBED MEDICATIONS?	
(8) VITAMINS?	
(9) HERBS?	

PLEASE TURN OVER

Please indicate if you have of have had any of the following: ***Write "C" for current problem, "P" for past problem*****:**

10. __ Headaches
11. __ Sinus trouble
12. __ Loss of smell
13. __ Allergies
14. __ Hay fever
15. __ Loss of taste
16. __ Inflammation of throat
17. __ Twitching of face
18. __ Loss of memory
19. __ Dizziness
20. __ Fatigue
21. __ Depression
22. __ Fainting
23. __ Ringing in ears
24. __ Loss of balance
25. __ Visual disturbances
26. __ Lights bother eyes
27. __ Cold sweats
28. __ Sleeping problems
29. __ Diarrhea
30. __ Constipation
31. __ Incontinence
32. __ Neck pain
33. __ Muscle spasms in neck
34. __ Grinding/Grating sounds in neck
35. __ Shoulder pain/tightness
36. __ Arm pain/tightness
37. __ Pins/needles and/or numbness in shoulders and arms
38. __ Cold hands
39. __ Shortness of breath
40. __ Mid-back pain
41. __ Stomach trouble
42. __ Anxiety
43. __ Inner tension
44. __ Irritability
45. __ Indigestion/reflux
46. __ Intestinal gas
47. __ Ulcers
48. __ Low back pain
49. __ Leg pain
50. __ Hip pain
51. __ Pins/needles and/or numbness in legs
52. __ Painful joints
53. __ Swollen joints
54. __ Swollen ankles
55. __ Foot pain
56. __ Cold feet
57. __ Menstrual irregularity/cramps
58. __ Other_____
59. __ Other_____
60. __ Other_____

61. Do you smoke? No or Yes (amount) _____
62. Alcohol Intake: _____beer(s) /Liquor / wine **PER** day / week / month / year. ***(Please circle)***
63. Females: Are you pregnant? Yes No Not sure **(*Please circle)***

Please indicate if you or a family member has had any of the following: ***Write "S" for self, "F" for family member:***

64. __ Heart Disease
65. __ Cancer
66. __ Gastrointestinal Disease
67. __ Diabetes
68. __ High/Low blood pressure
69. __ Memory/mood disorder
70. __ Stroke
71. __ Asthma
72. __ Thyroid problem

The purpose of this office is to provide society with a form of health care
that concerns itself with the true cause of **DIS-EASE**.
This health care is called **CHIROPRACTIC.**
The purpose of Chiropractic is to enable the individual to express 100% of his/her potential.

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

I hereby authorize my insurance company to pay directly to Family Chiropractic Centers the benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to the 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 file where they may be seen at any time while a patient of this office.

_____ _____
Patient's/Guardian's Signature Date

_____ _____
Signature Authorizing Care Date

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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
● ● ● ● ● ● ●
● ● ● ● ● ●

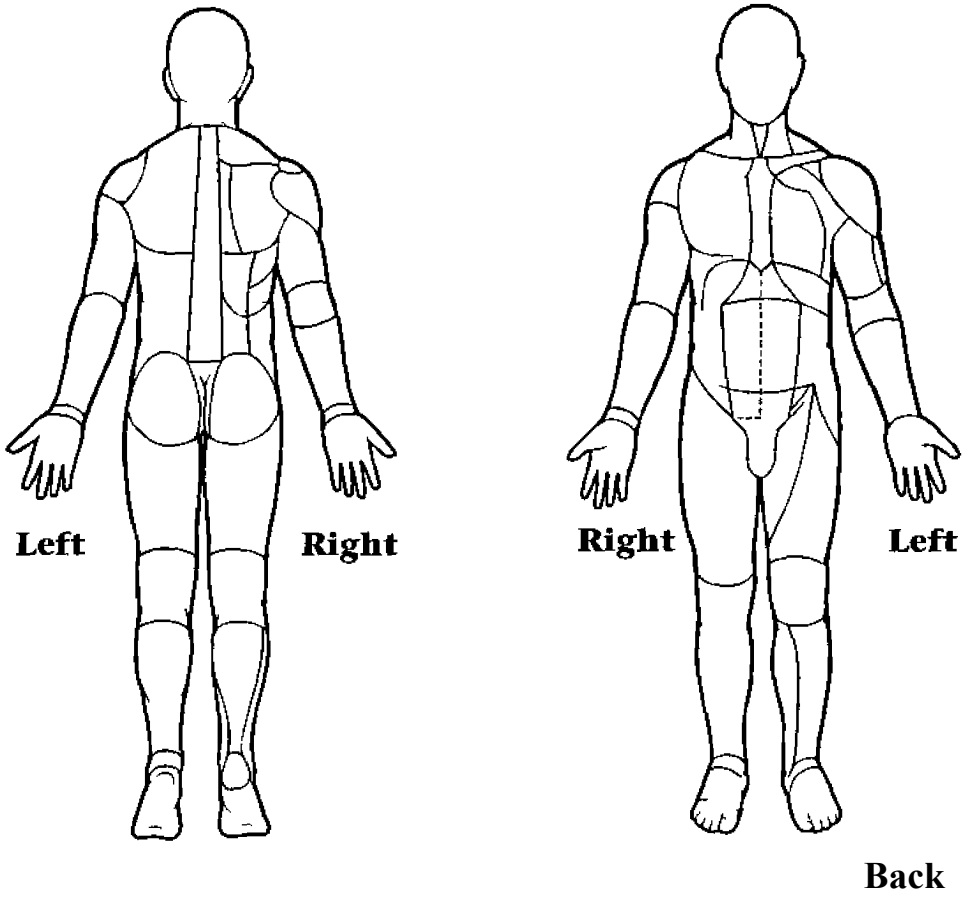
Stabbing
/ / / / / / / / /
/ / / / / / / /

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

Pain Chart (full body)

Patient's Name

Draw location and type of pain on the body 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

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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

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

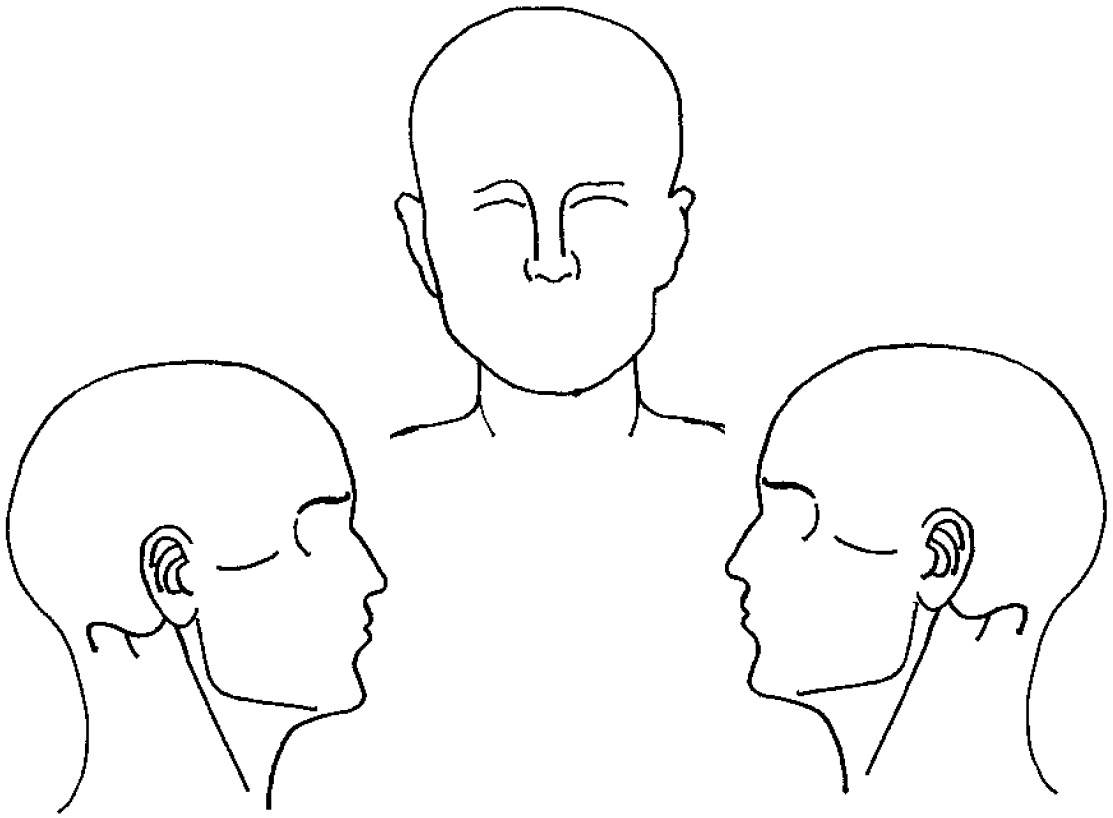
Stabbing
/ / / / / / / /
/ / / / / / /

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

Pain Chart (head only)

Patient's Name

Draw location and type of pain on the 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

Family Chiropractic Center of Bayonne's Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Family Chiropractic Center of Bayonne** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of **Family Chiropractic Center of Bayonne**. I understand that diagnosis or treatment of me by the doctors and practitioners of the **Family Chiropractic Center of Bayonne** 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 healthcare operations of the practice. **Family Chiropractic Center of Bayonne** is not required to agree to the restrictions that I may request. However, if **Family Chiropractic Center of Bayonne** agrees to a restriction that I request, the restriction is binding on **Family Chiropractic Center of Bayonne** and its doctors and practitioners. I have the right to revoke this consent, in writing, at any time, except to the extent that the doctors and practitioners of the **Family Chiropractic Center of Bayonne** 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 **Family Chiropractic Center of Bayonne's** Notice of Privacy Practices prior to signing this document. The **Family Chiropractic Center of Bayonne's** Notice of Privacy Practices is available at the front desk. 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 operations of the **Family Chiropractic Center of Bayonne**. The Notice of Privacy Practices for **Family Chiropractic Center of Bayonne** is also provided on the wall in the waiting area and on **Family Chiropractic Center of Bayonne's** website at www.fccofbayonne. This Notice of Privacy Practices also describes my rights and the **Family Chiropractic Center of Bayonne's** duty with respect to my protected health information. **Family Chiropractic Center of Bayonne** 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 **Family Chiropractic Center of Bayonne'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.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority