

Family Chiropractic Center of Bayonne

Dr. Noah De Koyer

734 Broadway | Bayonne | New Jersey 07002

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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 | |
| <input type="checkbox"/> MARRIED | <input type="checkbox"/> SINGLE | NO. OF CHILDREN | | REFERRED BY: | |
| <input type="checkbox"/> DIVORCED | <input type="checkbox"/> WIDOWED | | | | |
| 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: | | | | IF SO: Date of Injury | |
| <input type="checkbox"/> Auto Accident <input type="checkbox"/> On the Job 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? <i>IF YES, PLEASE DESCRIBE IN BOXES TO THE RIGHT</i> | 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 or have had any of the following: Write "C" for current problem, "P" for past problem:

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

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. <input type="checkbox"/> Heart Disease | 67. <input type="checkbox"/> Diabetes | 70. <input type="checkbox"/> Stroke |
| 65. <input type="checkbox"/> Cancer | 68. <input type="checkbox"/> High/Low blood pressure | 71. <input type="checkbox"/> Asthma |
| 66. <input type="checkbox"/> Gastrointestinal Disease | 69. <input type="checkbox"/> Osteoporosis/Osteopenia | 72. <input type="checkbox"/> Thyroid problem |

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 Center of Bayonne** 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 Chart (full body)

Pain Representation

Ache

V 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 O O

Pins & Needles

● ● ● ● ● ● ● ● ● ●
● ● ● ● ● ● ● ●

Stabbing

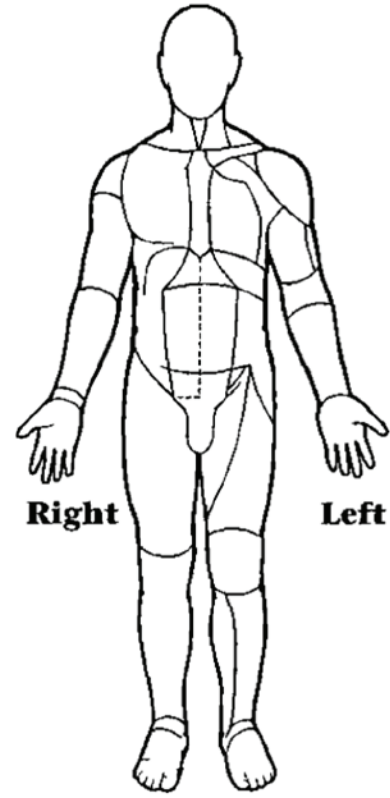
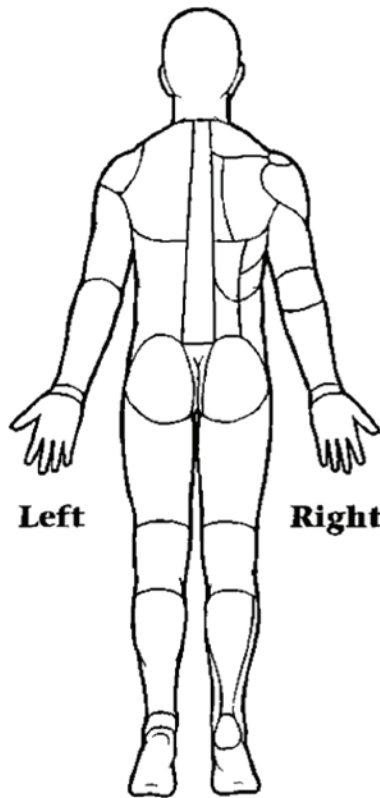
//////
//////

Other

X 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 outline and mark the degree on the pain line at the bottom of the page.



Back

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 V

Burning

=====
=====

Numbness

O O O O O O O O O O
O O O O O O O O

Pins & Needles

● ● ● ● ● ● ● ● ● ●
● ● ● ● ● ● ● ● ● ●

Stabbing

//////
//////

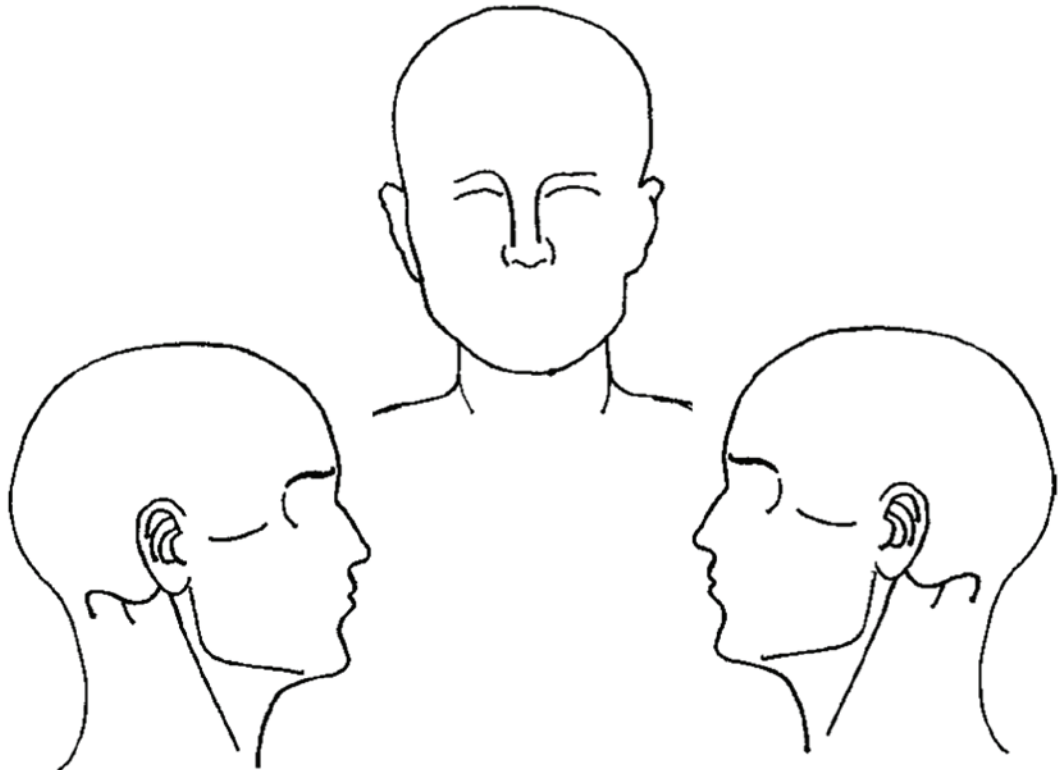
Other

X X X X X X X X
X X X X X 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 doctor of **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 doctor.

I have the right to revoke this consent, in writing, at any time, except to the extent that the doctor of **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 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 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.FamilyChiropracticCenter.info. 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