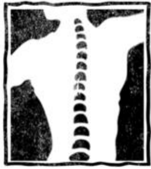


ADULT

New Practice Member
Intake Form

TODAY'S DATE: __________________ Who may we thank for referring you to this office? ____

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: ______-______-______ Age: ______ ☐ Male ☐ Female

Address: ____ City: _________________________ State: _____ Zip: ____________

Home Phone: ____ Work Phone: ____

Cell Phone: ____ Cell Carrier: ____

E-mail: ____ Social Security #: ____

Preferred Method of Contact: ☐ Email ☐ Text ☐ Call

Employer: ____ Occupation: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name: ____

# of children, names, and ages: ____

Who is your Primary Care Provider? ____ May we contact your provider if needed? ☐ Yes ☐ No

Emergency Contact Name & Number: ____ Relationship: ___________________

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

Primary Complaint: ____ Onset Date: _________________

Secondary Complaint: ____ Onset Date: _________________

Third Complaint: ____ Onset Date: _________________

Fourth Complaint: ____ Onset Date: _________________

Fifth Complaint: ____ Onset Date: _________________

Using the complaint(s) you listed above, rate the complaint(s) by ***circling the number***. On a scale of 0 to 10, 0 is no pain and 10 is the worst pain.

Primary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fifth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

PAST HISTORY

Please describe any past injuries, surgeries, and diseases. **If none, please write "NONE"** in the appropriate category.

	How long ago?	Type of care received?	By whom?
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. **Smoking:** ☐ cigars ☐ pipe ☐ cigarettes ☐ e-cig ☐ hookah — How often? ☐ daily ☐ weekends ☐ occasionally ☐ never
2. **Alcoholic Beverages:** average # of drinks _________ — How often? ☐ daily ☐ weekends ☐ occasionally ☐ never
3. **Recreational Drug use:** ☐ marijuana ☐ other: _______________ — How often? ☐ daily ☐ weekends ☐ occasionally ☐ never
4. **Exercise:** ☐ heavy ☐ moderate ☐ light — How often? ☐ daily ☐ weekends ☐ occasionally ☐ never

MEDICATIONS & SUPPLEMENTS

List all prescription and non-prescription vitamins, supplements, and medications. **If none, please write "NONE."**

____

____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? ☐ cancer ☐ stroke ☐ high blood pressure ☐ diabetes ☐ other

Please explain any boxes you have checked: ____

ACTIVITIES OF LIFE

Please identify how your current condition(s) is affecting your ability to carry out the following activities of daily living:

Lift Groceries/Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Showering/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming/Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ______________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

If you have ever been diagnosed with any of the following conditions, please indicate by selecting the following letters:
P = had in the **P**ast **C** = **C**urrently have **N** = **N**ever have had

Condition				Condition			
Cancer	☐ P	☐ C	☐ N	Asthma	☐ P	☐ C	☐ N
Stroke	☐ P	☐ C	☐ N	Seasonal Allergies	☐ P	☐ C	☐ N
Heart Attack	☐ P	☐ C	☐ N	Food Allergies	☐ P	☐ C	☐ N
Diabetes	☐ P	☐ C	☐ N	Learning Disability	☐ P	☐ C	☐ N
Migraine	☐ P	☐ C	☐ N	ADD / ADHD	☐ P	☐ C	☐ N
Tumors	☐ P	☐ C	☐ N	Hormonal Imbalances	☐ P	☐ C	☐ N
Osteoarthritis	☐ P	☐ C	☐ N	Prostate Problems	☐ P	☐ C	☐ N
Dislocation	☐ P	☐ C	☐ N	Reproductive Problems	☐ P	☐ C	☐ N
High Blood Pressure	☐ P	☐ C	☐ N	Hepatitis A, B, or C	☐ P	☐ C	☐ N
Low Blood Pressure	☐ P	☐ C	☐ N	Broken Bone	☐ P	☐ C	☐ N

If you have ever experienced any of the following conditions, please indicate by selecting the following letters:
P = had in the **P**ast **C** = **C**urrently have **N** = **N**ever have had

Condition				Condition			
Neck Pain	☐ P	☐ C	☐ N	Sinus / Drainage Problem	☐ P	☐ C	☐ N
Jaw Pain / TMJ	☐ P	☐ C	☐ N	Dizziness	☐ P	☐ C	☐ N
Shoulder Pain	☐ P	☐ C	☐ N	Loss of Balance	☐ P	☐ C	☐ N
Upper or Midback Pain	☐ P	☐ C	☐ N	Fainting	☐ P	☐ C	☐ N
Low Back Pain	☐ P	☐ C	☐ N	Double or Blurred Vision	☐ P	☐ C	☐ N
Hip Pain	☐ P	☐ C	☐ N	Ringing in Ears	☐ P	☐ C	☐ N
Chest Pain	☐ P	☐ C	☐ N	Hearing Loss	☐ P	☐ C	☐ N
Pain w/ Cough or Sneeze	☐ P	☐ C	☐ N	Depression	☐ P	☐ C	☐ N
Foot Pain	☐ P	☐ C	☐ N	Irritability	☐ P	☐ C	☐ N
Knee Pain	☐ P	☐ C	☐ N	Mood Swings	☐ P	☐ C	☐ N
Swollen / Painful Joints	☐ P	☐ C	☐ N	Sleeping Difficulty	☐ P	☐ C	☐ N
Frequent Colds or Flu	☐ P	☐ C	☐ N	Bed Wetting	☐ P	☐ C	☐ N
Convulsions / Epilepsy	☐ P	☐ C	☐ N	Eating Disorder	☐ P	☐ C	☐ N
Tremors	☐ P	☐ C	☐ N	Menstrual Problems / PMS	☐ P	☐ C	☐ N
Digestive Problems	☐ P	☐ C	☐ N	Menopausal Symptoms	☐ P	☐ C	☐ N
Heartburn / Acid Reflux	☐ P	☐ C	☐ N	Infertility	☐ P	☐ C	☐ N
Ulcers	☐ P	☐ C	☐ N	Impotence / Sexual Dysfunction	☐ P	☐ C	☐ N
Skin Problems	☐ P	☐ C	☐ N	Numb/Tingling arms, hand, fingers	☐ P	☐ C	☐ N
Breathing Difficulty	☐ P	☐ C	☐ N	Numb/Tingling legs, feet, toes	☐ P	☐ C	☐ N

I hereby authorize payment to be made directly to ADJUST Chiropractic Health Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this form or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ADJUST Chiropractic Health Center for any and all services I receive at this office.

____ ________________________

Patient or Authorized Person's Signature **Date Form Completed**

____ ________________________

Doctor Signature **Date Form Reviewed**

QUADRUPLE VISUAL ANALOGUE SCALE

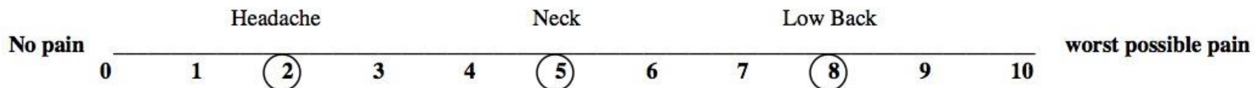
Patient Name ____ Date __________________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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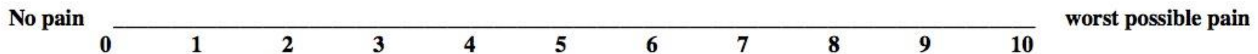
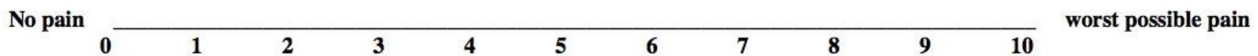
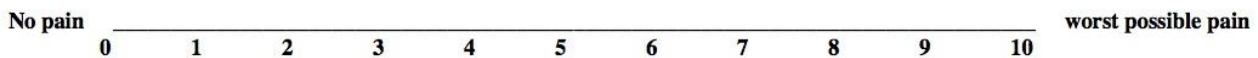
1 – What is your pain RIGHT NOW?



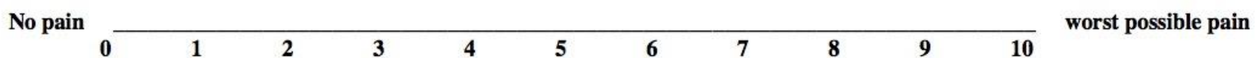
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at ADJUST Chiropractic Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____	_______ / _______ / _______
Patient or Authorized Person's Signature	**Date**

REGARDING: X-rays/Imaging Studies

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a CD is $15.00. This fee must be paid in advance.** The CD will be available for pick up within 72 hours of prepayment on any regular practice hours day. Shipping will be an additional fee.

Please note: X-rays are utilized in the office to help locate and analyze **vertebral subluxations**. These x-rays are not to be used to investigate for medical pathology. The doctors at ADJUST Chiropractic Health Center do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I, therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____	_______ / _______ / _______
Patient or Authorized Person's Signature	**Date**

FEMALES ONLY

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see a Chiropractic Assistant for further explanation.

☐ The first day of my last menstrual cycle was on _____ - _____ - _____ (*Month – Day – Year*)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

____	_______ / _______ / _______
Patient or Authorized Person's Signature	**Date**

ADJUST CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to you health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled "**HIPAA**" on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes: discussion with other healthcare providers in your care.
2. Inadvertent disclosure: open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes: to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: to process a claim or aid in investigation.
5. Emergency: in the event of a medical emergency we may notify a family member.
6. For public health and safety: in order to prevent or lessen a serious or eminent threat to the health or safety of a person.
7. To Government agencies or Law Enforcement: to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefit purposes.
9. Deceased persons: discussion with coroner and medical examiners in the event of a patient's death.
10. Telephone calls or email and appointment reminders: **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership: in the event this practice is sold, the new owners would have access to your Personal Health Information.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records **at no charge**, when timely notice is provided (72 hours). **X-rays are original records and you are therefore not entitled to them.** If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Jason Abaza or Dr. Marissa Abaza at (973) 957-0836. If the doctors are unavailable, you may make an appointment with our receptionist to see a doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:
DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201

I have received a copy of ADJUST Chiropractic Health Center Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserved the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that is maintains past and present.

I am aware that a more comprehensive version of the "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ________________________
Patient's PRINTED Name Date of Birth

____ ________________________
Patient Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: ____ Date of Birth: ______________________________________

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released, and will remain in effect until terminated by me in writing, to:

- ☐ Spouse ____
- ☐ Child(ren) ____
- ☐ Other ____
- ☐ Information is not to be released to anyone.

Messages

If I need to be contacted, please call my:

- ☐ home phone: ____
- ☐ work phone: ____
- ☐ mobile number: ____

If unable to reach me:

- ☐ you may leave a detailed message.
- ☐ please leave a message asking me to return your call.
- ☐ other: ____

The best time to reach me is (*day*) ____between (*time*) _____________________________________.

____ _____________________________

Patient Signature Date