Back2Health Chiropractic & Rehab Center, LLC

Patient Intake Form

Patient Information:

Last Name: _____ *First Name:* _____ *Sex:* _____

Date of Birth: _____ *SS#:* _____-_____-_____

Address: _____ *City:* _____ *State:* _____

Zip Code: _____ *Work#:* ( ) _____-_____ *Home#:* ( ) _____-_____

Email: _____ *Mobile#:* ( ) _____-_____

Marital Status: Single _____ *Married* _____ *Divorced* _____ *Widowed* _____ *Domestic Partner* _____

Employer's Name: _____ *Occupation:* _____

Physician's Name: _____ *Diagnosis:* _____

Injury: Work or Auto related? _____ *Allergies or Medical Precautions:* _____

Emergency Contact: _____ *Phone#:* ( ) _____-_____

Insurance Information:

Insurance Co. Name: _____ *Policy#:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Insured's Name: _____ *SS#:* _____-_____-_____ *Date of Birth:* _____

Address: _____ *City:* _____ *State:* _____ *Zip Code:* _____

Insured's Employer's Name: _____

I hereby accept responsibility for the cost of this examination or treatment in the event that the Insurance Company denies this claim. I hereby understand and agree to accept responsibility of the cancellation policy of this office: Giving 24 hour notice to cancel: If I am unable to comply but reschedule the appointment before and within the end of the week, no charge will be made. Otherwise a $45.00 fee will be charged for the missed session. (Please note that it is your responsibility- Insurance companies do not reimburse for missed appointments.

Patient's signature: _____

Date Signed: _____

Back2Health Chiropractic & Rehab Center, LLC

Patient Questionnaire/ History

Name: _____ *Date of Birth:* _____ _____*Right or* _____*Left handed*

What is your Chief Complaint? _____

_____

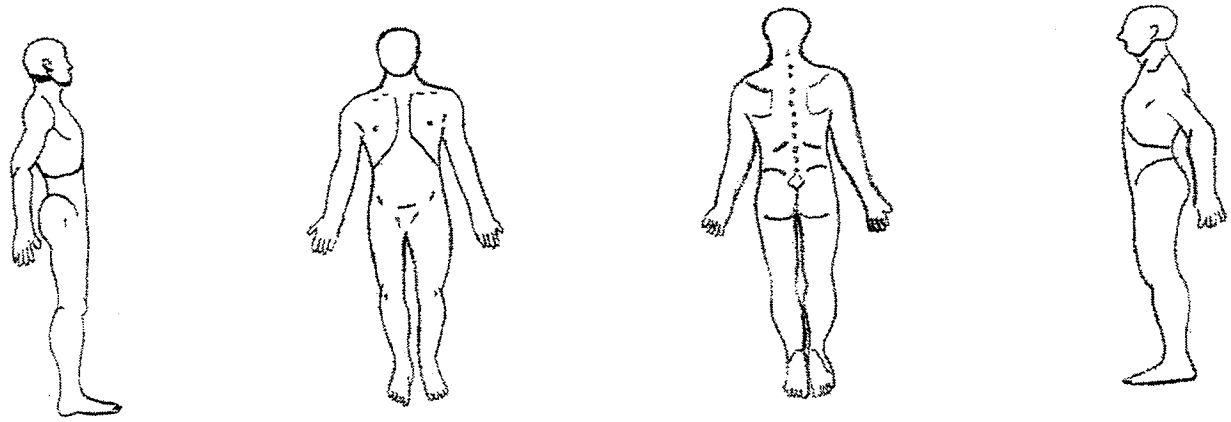
Rate your chief complaint in order of severity from worst (5) to least (1)

*Pain*____ *Decreased Motion*____ *Swelling/edema*____ *Stiffness*____ *Loss of function*_____

Where is your problem? Indicate on the body chart. Pain xxx: Numbness ooo: Tingling zzz:

Indicate the nature of your pain and symptoms: ___*Sharp* ___*Dull* ___*Piercing*___*Shooting* ___*Aching*

__ *Deep* ___*Superficial* ___*Tingling* ___*Numbness* ___*Intermittent* ___*Burning* ___*Stabbing*



When and how did this problem begin? _____

_____

What makes your symptoms/ pain worse? _____

_____

What makes your symptoms/ pain lessen? _____

_____

Rate your pain on a visual scale (0-10) 0 no pain 10 excruciating pain: _____

*Worst it has been*_____ *Past 2 to 4 weeks*_____ *Past 24 hours*_____ *At this moment*_____

Are your symptoms worse in the: _____*Morning* _____*Afternoon* _____*Evening* _____ *Inconsistent*_____

Are your symptoms: _____*Improving* _____*Worse* _____*Stable*_____

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Medical History

*Has this problem affected your daily life or routine? Briefly describe in what ways.*_____

_____

_____

*Have you had past similar episodes of this current problem? If yes, were you treated with; (circle disciplines, which apply) Physical Therapy, Acupuncture, M.D. (Meds, TPI's) Massage Therapist, Chiropractor, Pilates, General Exercise, exercise with trainer, Self medicated (Advil), ignored it, other, Did they help to alleviate your symptoms?*_____

_____

*Have you undergone any special tests for this condition? (X-rays, MRI's, ETC) If yes, do you know the results?*_____

_____

Please answer the following questions:

	Yes	*No*
1) Do the current problems interrupt your sleep?		
2) Do your symptoms change with coughing or sneezing?		
3) Have you had any recent changes in bowel or bladder function?		
4) Do you experience any dizziness or vertigo?		
5) Have you had any recent change in your weight or appetite?		
6) Do you have any intolerance to hot or cold?		
7) Do you have any bruising or bleeding disorders?		
8) Have you had any skin changes, such as rashes or discoloration?		
9) Have you experienced any changes in your vision, such as blurring, double vision, or decrease in your visual fields?		
10) Have you had a recent episode of nausea/vomiting?		
11) Are you pregnant?		
12) Do you have osteoporosis? Date of your last bone scan:		
13) Do you have any allergies?		
14) Have you noticed any shortness of breath or decrease in exercise tolerance?		
15) Do you use any assistive devise? (cane foot orthotics)		
16) Do you have high blood pressure?		
17) Do you have any cardiac problems?		
18) Do you have diabetes?		
19) Have you ever had cancer of any sort?		
20) Do you have a history of neck or back problems?		

*Any other illness, past injuries I should be aware of?*_____

*Past surgeries___yes, ___no, give brief details:*_____

*List the medications you are currently taking (over the counter/prescription):*_____

_____

Back2Health Chiropractic Center, LLC
Chiropractic & Physical Therapy Rehabilitation Center
Dr. Edward Shmaruk, D.C
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T (201) 820-3343 F (201) 820-3344
drshmaruk@back2healthnow.com

ACCIDENT INFORMARTION

Is this condition due to an accident? ☐ Yes ☐ No

If yes, Date of accident

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To Whom have you made a report of your accident ? ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

NON-ACCIDENT STATEMEMT

I the undersigned certify the treatment being rendered to me at Back2Health Chiropractic & Physical Therapy Rehabilitation center it is not related to any auto accident, workers' comp., or personal injury accident. My signature below indicates that I have read and understand the above statement.

Patient Signature _____ Date_____

Guardian signature _____ Date_____

AUTHORIZATION AND REQUEST FOR MEDICAL RECORDS

To: _____

_____

_____

PHN: _____ FAX: _____

I, _____ hereby authorize you to release my health information to:

Edward Shmaruk, DC
33-00 Broadway Suite209, Fair Lawn, NJ 07410
Telephone: 201-820-3343
Fax: 201-820-3344

The information to be disclosed to and used by the above is for the following purpose: Health assessment

Information to be disclosed:

☐ History and physical examination ☐ Progress notes

☐ Operative reports ☐ Discharge summary

☐ All diagnostic reports such as x-ray, CT scans, MRI reports

I understand I have the right to revoke this authorization in writing at any time. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire on the following date, event or condition: Unlimited. I understand that authorizing the disclosure of this health information is voluntary. If I refuse to sign, that will not interfere with my ability to obtain treatment. I understand any unauthorized re-disclosure of this information will no longer be protected by the federal privacy regulations.

_____ _____ _____

DOB SSN DOA

_____ _____

Patient Signature Date

If legal representative, sign below and state relationship and authority to do so.

_____ _____

Legal Representative Date

_____

Relationship to Patient

AUTHORIZATION TO TREAT
INFORMED CONSENT | ASSIGNMENT OF INSURANCE BENEFITS
GUARANTEE OF PAYMENT | RECEIPT OF PRIVACY PRACTICES

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named throughout this writing and/or their preceptor and/or other licensed doctors of chiropractic who now or in the future may treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at this clinic or offices associated with this clinic.

I have had an opportunity to discuss/raise any questions with the doctors and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment is utilized for the improvement of spinal function relative to range of motion. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation there of, as well as the doctor's judgment and expertise in working with like cases.

I, the undersigned, authorize the assignment of my insurance rights and benefits directly to Dr. Edward Shmaruk, DC and authorize the release of such information as is needed to process and collect insurance claims. If applicable, I, the undersigned, request that payment of authorized Medicare benefits be made on my behalf to Dr. Edward Shmaruk, DC for services furnished to me by Dr. Edward Shmaruk, DC and the support staff of. I, the undersigned, authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I, the undersigned, agree that filing insurance does not guarantee payment and if payment is not made within 90 days by my insurance, the balance due is my responsibility. I, the undersigned, hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I, the undersigned, acknowledge receipt, either being given or having asked for, of this practice's Privacy Notice.

Patient Name Printed	**Patient Signature**	**Date**
Guardian Name Printed	**Guardian Signature**	**Date**

PERMISSION TO EXAMINE AND TREAT A MINOR

I, the undersigned legal guardian of _____ a minor, do hereby authorize and consent to any and all treatments, tests or diagnosis rendered by Dr. Edward Shmaruk, DC or his support staff. It is understood that this authorization is given in advance of any specific treatments, tests or diagnosis.

Guardian Name Printed	**Guardian Signature**	**Date**