FREEDMAN CHIROPRACTIC INITIAL INTAKE FORM –
ANSWER ALL QUESTIONS

Today's Date:_____ HRN: _____

Whom may we thank for referring you to this office? → _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____/_____/_____Age: _____ ☐ Male ☐ Female

Address:_____City:_____State:_____Zip: _____

E-mail Address:_____Home Phone:_____ Cell Phone:_____

Cell Carrier (Verizon, AT&T etc.): _____ Do you authorize this office to send: Emails ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Social Security #:_____Driver's License #: _____

Employer:_____Occupation: _____

Spouse's Name_____Spouse's Employer _____

Children's names and their ages: _____

Emergency Contact and number:_____Relationship: _____

HISTORY of COMPLAINT

Please identify your complaint(s) in their order of importance:

#1:_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ (0-10) ***On average:*** _____ (0-10) ***At its best:*** _____ (0-10) ***At its worst:*** _____ (0-10) **(Dr. use only) V.P.N.** _____

#2_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ (0-10) ***On average:*** _____ (0-10) ***At its best:*** _____ (0-10) ***At its worst:*** _____ (0-10) **(Dr. use only) V.P.N.** _____

#3_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ (0-10) ***On average:*** _____ (0-10) ***At its best:*** _____ (0-10) ***At its worst:*** _____ (0-10) **(Dr. use only) V.P.N.** _____

#4_____ ***Rate this complaint by number*: (NO PAIN) 0 - 10 (WORST PAIN)**

Right Now: _____ (0-10) ***On average:*** _____ (0-10) ***At its best:*** _____ (0-10) ***At its worst:*** _____ (0-10) **(Dr. use only) V.P.N.** _____

What relieves your symptoms? _____

What makes them feel worse? _____

When did the problem(s) begin?_____When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident or injury? ☐ No ☐ Yes, Describe _____

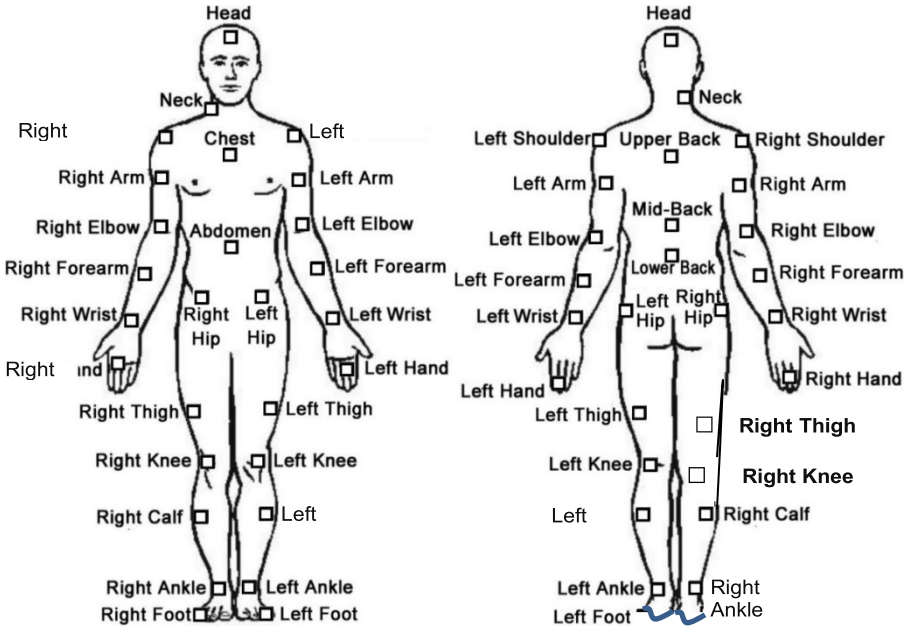
Above condition(s) ever been treated by anyone in the past? ☐No ☐Yes, by whom and when:_____

How long were you under care?_____What were the results? _____

Previous Chiropractor? ☐No ☐ Yes, who? _____

Patient's Name: _____ **Date:** _____

PLEASE MARK the areas on the diagram with the following **letters** to describe your symptoms:
A = Aching **D** = Dull **S** = Sharp/ Stabbing **R** = Radiating **B** = Burning **N** = Numbness **T=** Tingling



_____ ***Initial here if your condition doesn't restrict or limit your regular daily activities.***

OR

LIST RESTRICTED ACTIVITY:	AMOUNT YOU CAN PERFORM NOW…	… WITHOUT YOUR COMPLAINT?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

How long does your chief complaint last?

☐ Constantly	☐ Every day	☐ Five to six times a week
☐ Three to four times a week	☐ Two to three times a week	☐ One to two times a week
☐ Frequently	☐ Occasionally	☐ Intermittently
☐ Once a week	☐ Every other week	☐ Once a month

PLEASE identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem(s):

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

Please list all of your past jobs where you experienced physical, chemical or emotional stress: _____

List prescription & over the counter drugs you take: _____

Patient's Name: _____ **Date:** _____

For **EACH** condition indicate***: C = Currently Have P = in the Past N = Never had:***

___Broken Bone	_____Dislocations	_____Tumors	_____Rheumatoid Arthritis	_____Fracture
___Disability	____Cancer	_____Heart Attack	_____Osteoarthritis	_____Diabetes
___Stroke	_____Headache	_____Pregnant	_____Dizziness	_____Prostate Problems
___Loss of Balance	_____Neck Pain	_____Ulcers	_____Heartburn	_____Frequent Colds/Flu
___Jaw Pain, TMJ	_____Fainting	_____Heart Problem	_____Convulsions/Epilepsy	_____Digestive Problems
___Shoulder Pain	____Tremors	_____Double Vision	_____Colon Trouble	_____High Blood Pressure
___Upper Back Pain	_____Chest Pain	_____Blurred Vision	_____Diarrhea/Constipation	_____Low Blood Pressure
___Mid Back Pain	_____Ringing in Ears	_____Irritable	_____Impotence/Sexual Dysfun.	_____Pain w/Cough/Sneeze
___Low Back Pain	_____Hearing Loss	_____Hip Pain	_____Foot or Knee Problem	_____Difficulty Breathing
___Depression	_____PMS	_____Lung Problems	_____Back Curvature	_____Sinus/Drainage Problem
___Bed Wetting	_____Kidney Trouble	_____Scoliosis	_____Skin Problems	_____Menstrual Problem
___Mood Changes	_____Learning Disability	_____ADD/ADHD	_____Eating Disorder	_____Swollen/Painful Joints
___Liver Trouble	_____Trouble Sleeping	_____Allergies	_____Hepatitis (A B C)	_____Gall Bladder Trouble
___Numbness/Tingling arms, hands, fingers		_____Numbness/Tingling legs, feet, toes		_____Asthma

Other condition(s) not listed: _____

Rate how well you handle emotional stress on a scale from: 0 (Fragile) to 10 (Nothing bothers you): _____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never ❑ Quit __ yrs. ago

2. Alcoholic Beverage: consumption occurs ---------→ ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ----------→ ❑ Daily ❑ Weekends ❑ Occasionally ❑Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect your daily life? (See Page 2)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister(s) ❑ brother(s) ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes: _____

I hereby authorize Ken Freedman, DC, or the employees of Freedman Chiropractic Center, LLC, to provide services to me or, if applicable, my minor child. I also authorize payment to be made directly to ***Freedman Chiropractic Center, LLC***, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application 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 ***Freedman Chiropractic Center, LLC*** for any and all services my minor child / I receive at this office.

_____ **Patient or Authorized Person's Signature**

_____/_____/_____ **Date Completed**

_____ **Doctor's Signature**

_____/_____/_____ **Date Form Reviewed**

DEAR PATIENT

When filling out all paperwork,
please be aware that insurance carriers
only pay for care they deem
"medically necessary."

Therefore, please indicate
all complaints in detail.
Most importantly, indicate exactly
how your complaint is
interfering with your daily activities.

FREEDMAN CHIROPRACTIC CENTER, LLC

CONFIDENTIAL PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____ **Age** _____

If you are suffering from a condition, what was the cause:

_____

_____

_____

OR

_____ **Presently, I am not suffering from pain nor have a condition. I want to ensure that my body is functioning at its best, so I can be healthier and have stronger immunity**

WOULD YOU LIKE TO FIND OUT ABOUT YOUR INSURANCE COVERAGE? IF SO, PLEASE COMPLETE THE INSURANCE INFORMATION BELOW. WE WILL CONTACT YOUR INSURANCE CARRIER AND ADVISE YOU WHAT BENEFITS ARE AVAILABLE.

CONFIDENTIAL INSURANCE INFORMATION

Insurance carrier:_____

Policy Holder's Name:_____ **Policy Holder's date of birth:** _____

Policy Holder's employer:_____ **Policy/ID#:** _____

Policy Holder's SSN:_____ **Group#:**_____

Insurance Company Provider's Phone #: _____ - _____ - _____

Insurance Company Phone #: _____ - _____ - _____ **(if no provider contact information is given)**

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

FREEDMAN CHIROPRACTIC CENTER, LLC- NOTICE OF PRIVACY PRACTICE

This office is requires 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 your 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 area. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes-discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean 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 or a person or general public.
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 benefits purposes.
9. Deceased persons- discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails 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 you PHI.

YOUR RIGHTS

1. To receive an accounting of disclosers
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailing 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.

I have received a copy of Freedman Chiropractic Center, LLC's Patient Privacy Notice. I understand my rights as well as the Practices 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 reserves 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 it maintains past and present.

I am aware that a more comprehensive version of this "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.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient's Signature Date

_____ _____

Witness Date

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Ken Freedman at 732-254-6011. If he is unavailable, you many make an appointment with our receptionist to see him within 72 hours or 3 business days. If you are still nor satisfied with the manner in which this office handles your compliant, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201