MEDICAL HISTORY FORM

FIT FOR LIFE CHIROPRACTIC CENTER
74 HORSENECK ROAD
MONTVILLE, NJ 07045

Patient Name:_____ **Sex**: M F **Date**: _____

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

Home Phone: ( )_____ **Cell Phone ( )**_____ **Age:** _____

Date of Birth:____/____/_____ **Employer:**_____ **Email:** _____

Subscriber Name:_____ **Subscriber's: D.O.B**: _____

Relation to Patient:_____ **Health Ins. Plan**:_____ **# of Family Members on plan**_____

Personal Status: (Please Circle) Single Married Divorced

What is our preferred method of contact? (Please Circle) Home Phone Cell Phone Email

Have you ever seen a chiropractor before? (Please Circle) Yes No **If yes, how long ago?** _____

Smoking Status:

Smokes every day	Smokes some days	Former Smoker	Never Smoked

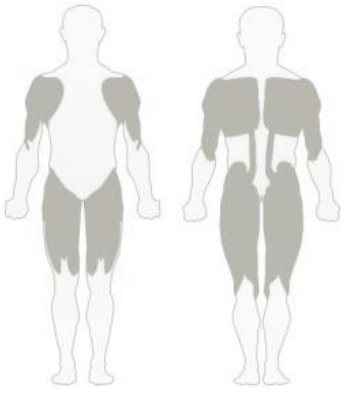
Vitals:

Height: _____ Weight: _____ Blood Pressure:_____/_____

Have you been diagnosed with?

Asthma? Y / N	Diabetes? Y / N Type? 1 / 2	High Blood Pressure? Y / N

1. **Indicate on the drawings below where you have pain / symptoms:**



Front Back

2. **How often do you experience your symptoms?**

☐ Constantly (76% - 100% of the time ☐ Frequently (51% – 75 % of the time
☐ Occasionally (26% - 50) of the time ☐ Intermittently (1% - 25% of the time

3. Please choose the location of the problem?

☐ Neck	☐ Head	☐ Hip Rt / Lt	☐ Jaw Rt / Lt
☐ Upper Back	☐ Shoulder Rt/ Lt	☐ Legs Rt / Lt	☐ Wrist Rt / Lt
☐ Mid Back	☐ Arm Rt / Lt	☐ Knee Rt / Lt	☐ Hand Rt / Lt
☐ Low Back	☐ Elbow Rt / Lt	☐ Ankle Rt / Lt	☐ Foot Rt / Lt

4. How would you describe the type of pain?

☐ Sharp	☐ Numb
☐ Dull	☐ Tingly
☐ Diffuse	☐ Sharp with motion
☐ Achy	☐ Shooting with motion
☐ Burning	☐ Stabbing with motion
☐ Shooting	☐ Electric like with motion
☐ Stiff	☐ Other: _____

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0 – 10 (10 being the worse), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please Circle)

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. What is your Occupation? _____

9. What do you do at work?

☐ SIT – Most / Half / Some of the day	☐ STAND – Most / Half / Some of the day
☐ MANUAL LABOR – Most / Half / Some of the day	☐ COMPUTER – Most / Half / Some of the day
☐ DRIVES – Most / Half / Some of the day	☐ TRAVELS – Most / Half / Some of the day

10. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

11. What kind of regular exercise do you preform?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

12. What type of exercise do you enjoy?

Aerobics	Bicycle	Hike	Jog/Run	Ski
Swim	Volleyball	Lift Weights	Basketball	Football
Hockey	Martial Arts	Soccer	Tennis	Baseball
Lacrosse	Golf	Walk	Pilates	Yoga

OTHER _____

13. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis M / F	☐ Diabetes M / F	☐ Lupus M / F
☐ Heart Problem M / F	☐ Cancer M / F	☐ ALS M / F

14. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have the condition listed below, place a check in the "present" column.

PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	High Blood Pressure
☐	☐	Neck Pain	☐	☐	Heart Attack
☐	☐	Upper Back Pain	☐	☐	Chest Pain
☐	☐	Mid Back Pain	☐	☐	Stroke
☐	☐	Low Back Pain	☐	☐	Angina
☐	☐	Shoulder Pain	☐	☐	Kidney Stones
☐	☐	Elbow/ Upper Arm Pain	☐	☐	Kidney Disorders
☐	☐	Wrist Pain	☐	☐	Bladder Infection
☐	☐	Hand Pain	☐	☐	Painful Urination
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems
☐	☐	Knee Pain	☐	☐	Abnormal Weight Gain/Loss
☐	☐	Ankle/ Foot Pain	☐	☐	Loss of Appetite
☐	☐	Jaw Pain	☐	☐	Abnormal Pain
☐	☐	Joint Pain/ Stiffness	☐	☐	Ulcer
☐	☐	Arthritis	☐	☐	Hepatitis
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer	☐	☐	General Fatigue
☐	☐	Tumor	☐	☐	Muscular Incoordination
☐	☐	Asthma	☐	☐	Visual Disturbances
☐	☐	Chronic Sinusitis	☐	☐	Dizziness
☐	☐	Other _____	☐	☐	Depression
☐	☐	Diabetes	☐	☐	Systemic Lupus
☐	☐	Excessive Thirst	☐	☐	Epilepsy
☐	☐	Frequent Urination	☐	☐	Dermatitis/ Eczema / Rash
☐	☐	Smoking/ Tobacco Use		FOR FEMALES ONLY:	
☐	☐	Drug/ Alcohol Dependence	☐	☐	Birth Control Pills
☐	☐	Allergies	☐	☐	Hormonal replacement
☐	☐		☐	☐	Pregnancy

15. Have you had your influenza vaccination this year? (please circle) Yes No

16. Please list all Prescription Medications you are currently taking:

Check here if not taking any medications: ☐

Name of Medication: i.e: Lipitor	**Strength and MD's instruction** i.e: 10mg, 2x daily	**Prescribing Physician**

17. Are you allergic to any medications? Please list each drug on a new line:

Check here if you do not have any medicinal allergies: ☐

Name of Drug: i.e. Penicillin	Symptom if Taken: i.e: Headache

17. Have you ever been hospitalized? ☐ No ☐ Yes

If yes, why?

_____

18. Have you had significant past trauma/surgery? ☐ No ☐ Yes

If yes, why?

_____

19. ☐ **Who else have you seen for your problem?**

☐ Chiropractor	☐ Neurologist	☐ Primary Care Phy
☐ ER Physician	☐ Orthopedist	☐ Other:_____
☐ Massage Therapist	☐ Physical Therapist	☐ No one

20. How long have you had this problem?_____**Day / Days /Months / Year / years**

21. How do you think your problem began?

_____

_____

22. What aggravates your Problem: (Please Circle)

Always There	Bending	Biking	Deep Breaths	Stairs	Coughing	Driving
Golfing	Painting	Standing	Sitting	Picking up child	Running/Jogging	Playing Sports
Sleeping	Sneezing	Stress	Using Phone	Bathing	Traveling	Turning over in Bed
Weather Change	Work	Computer	Lifting	Carrying Handbag	Pushing	Pulling
Dressing	Exercising	Household Chores	Gardening	Shoveling	Sweeping	Racking

Other _____

23. Whom may we thank for your referral? ☺ _____

PATIENT'S ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT FIT FOR LIFE CHIROPRACTIC CENTER IS PERMITTED BY LAW TO USE MY PERSONAL HEALTH INFORMTION TO FACILITATE PAYMENT OF ANY FEES AND EXPENSES. FIT FOR LIFE CHIROPRACTIC CENTER HAS AGREED TO ASSIST ME IN BILLING MY HEALTH INSURANCE, AUTO INSURANCE AND ANY AND ALL OTHER APPLICABLE COLLATERAL SOURCES. ALTHOUGH THE PRACTICE WILL AWAIT THEIR DIRECT PAYMENT, I AGREE I AM FULLY AND PERSONALLY RESPONSIBLE FOR ALL FEES I INCUR IN CONNECTION WITH SERVICES RENDERED FOR THE PURPOSE OF TODAY'S VISIT, AS WELL AS ANY FUTURE SERVICES FOR ANY CONDITION KNOWN OR AS OF YET UNKNOWN.

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT. I HEREBY AUTHORIZE FIT FOR LIFE CHIROPRACTIC CENTER TO PROVIDE ME WITH CHIROPRACTIC CARE IN ACCORDANCE WITH THE STATES STATUES.

Patient Signature _____

Date: _____

STATEMENT OF NON-ACCIDENT

I,_____, am currently receiving chiropractic care at this facility. Please know that this care is not related to any auto accident, worker's compensation injury, or any other type of injury in which there is a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing claims submitted to you by this chiropractic office. If you have any questions, do not hesitate to contact us personally.

_____ _____

Print Name **Signature**

Coordination of Benefits Statement

I assign directly to Dr. Fano/Fit for Life Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

_____ _____

Print Name Signature

Do you have a Secondary Insurance? (circle one) **YES** **NO**

Name of Secondary Insurance Company _____

Name of Policy Holder_____Policy ID# _____

_____ _____

Print Name Signature

Hippa Form

We are required by State and Federal Law to maintain the privacy of your patient file and protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the rights to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you, in writing, as soon as possible, following the changes. Any change in our privacy notice will apply for all of your health information in our files.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities, you should direct your complaint to:

Dr. David M Fano Privacy Officer

If you would like further information about our privacy policies and practices, please contact:

Dr. David M Fano Privacy Officer

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you lodge a complaint with this office or with the Secretary, your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever. This notice is effective as of the date of execution listed below. This notice, and any alterations or amendments made here will expire seven years after the date upon which the record was created. My signature acknowledges that I have read through this document and that upon my request I have received a copy of this notice for my personal records.

_____ _____ _____

Name (please print) Signature Date

If you are a minor, your parent or guardian must sign or in the event of other representation issues, please have the following executed by the appropriate representing party.

_____ _____ _____

Personal Representative (please print) Personal Representative Signature Date

Fit for Life Chiropractic Center

Dr. David M. Fano
74 Horseneck Road
Montville, NJ 07045
973-265-0700

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____
Patient's Signature Date

X-RAY QUESTIONNAIRE: **FOR WOMEN ONLY**

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- ❑ There is a possibility that I may be pregnant at this time.
- ❑ Yes. I am definitely pregnant
- ❑ No. I am definitely not pregnant at this time
- ❑ I request that x-ray films not be taken because _____

_____

Date of last menstrual period: _____

AUTHORIZATION FOR TAKING X-RAY FILMS

I understand and agree that this service rendered to me is charged directly to me and I'm responsible for payment of any unpaid balance directly to the Doctor. I further agree that the above named Doctor will keep the X-Rays at this office. X-Rays will be released upon proper authorization and consent signed by me, the patient. I consent to having X-rays taken at the above office by the above Doctor.

_____
Patient's Signature Date

Lower Back

Name:_____ **Date:**_____ **File#:**_____

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 – Pain Intensity
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of pain, I am unable to do any washing and dressing without help.

SECTION 3 – Lifting
- ☐ I can lift heave weights without extra pain.
- ☐ I can life heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned. (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking, but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – Sitting
- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately

SECTION 6 – Standing
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it causes pain immediately.

SECTION 7 – Sleeping
- ☐ I get no pain in bed
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – Social Life
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing...
- ☐ Pain has restricted my social life and I do not go out much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain

SECTION 9 - Traveling
- ☐ I get no pain while traveling
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does now compel me to seek alternative forms of travel.
- ☐ I get extra pain while travelling, which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except when done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 – Changing Degrees of Pain
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates, but overall is definitively getting better.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain gradually worsening.
- ☐ My pain is rapidly worsening

Patient Signature: _____

Neck Disability Index

Name:_____ **Date:**_____ **File#:**_____

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE ONE BOX THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY SECTION RELATE TO YOU, PLEASE MARK THE MOX THAT MOST CLOSELY DESCRIBES YOUR PRESENT DAY SITUATION.

SECTION 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of my self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – Lifting
- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if items are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK
- ☐ I can so as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – Concentration
- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – Driving
- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive because of severe neck pain.
- ☐ I can't drive my car at all because of neck pain.

SECTION 9 – Reading
- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all

SECTION 10 – Recreation
- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have some neck pain with most recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I can hardly so recreational activities sue to neck pain.
- ☐ I can't do any recreational activities due to neck pain

Patient Signature: _____

Score:_____[50] % Score= _____

INFORMED CONSENT TO TREAT

Please read this entire section prior to signing. It is important that you understand the information contained in this section. If anything is unclear, please ask questions before you sign.

DO NOT SIGN THIS CONSENT TO BE TREATED UNTIL YOU HAVE READ, UNDERSTAND AND ASKED ANY QUESTIONS THAT YOU MAY HAVE!

Chiropractic Manipulation and Therapy Risks:

As with any healthcare procedure, there are certain complications which may arise during or after chiropractic manipulation of the spine and/or extremities and with the use of physical therapy treatments. These complications include but are not limited to: fractures of bones, spinal disc injuries, joint dislocations, muscle injuries, nerve injury, worsening symptoms and rib injuries. These complications are generally described as rare.

Manipulation of the neck has been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million or more neck adjustments.

Having been informed of these risk factors, I hereby attest that I understand the terms used in the above paragraphs and give my consent for chiropractic treatment.

_____ _____

Patient/Guardian Name Printed Date

_____ _____

Patient/Guardian Signature Relationship to Patient

I have addressed any questions regarding consent to treat:

_____

Doctor Signature