CHIRO REHAB CENTER

220 Hamburg Turnpike Suite 14A • Wayne, NJ 07470 | T:(862) 336-1600 • F:(862) 336-1601

Patient Information

Name: _____

Address: _____

City: _____ **State:** ___ **Zip:** _____

Date of Birth: ___/___/___

Social Security Number: _____

Contact Information

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Cell phone carrier (for appointment reminders only)**:**

◯ Verizon ◯ AT&T ◯ Sprint ◯ T-Mobile

◯ Other: _____

Race: ◯ White ◯ Asian ◯ African American ◯ Hispanic ◯ American Indian ◯ Prefer not to answer ◯ Other: _____

Sex: ◯ Male ◯ Female ◯ Other ◯ Prefer not to answer

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Other

Name of Spouse: _____

Employer: _____

Insurance Information

Are you covered by any health insurance?

Insurance Company: _____

ID Number: _____

Group Number: _____

Name of Insured: _____

Relationship to you: _____

Reason for Visit _____

_____

_____

Are any other Doctor(s) treating you for this problem? ◯ Yes ◯ No

Name: _____

Phone Number: _____

Were you in an accident? ◯ YES ◯ NO

☐ Motor Vehicle Accident ☐ Fall

☐ Worker's Compensation ☐ Lifting

☐ Other: _____

If motor vehicle accident, please provide details in the dedicated section on the following page.

Have you had any serious illness' in the past?

◯ **No** ◯ **Yes:** _____

Is there any chance you are pregnant? ◯ Yes ◯ No

I understand that AKM Chiro-Rehab Center, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the AKM Chiro-Rehab Center, LLC will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurane information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize AKM CHiro-Rehab Center, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission ro leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

PATIENT SIGNATURE: _____ **DATE:** _____
(Guardian's signature if patient is a minor)

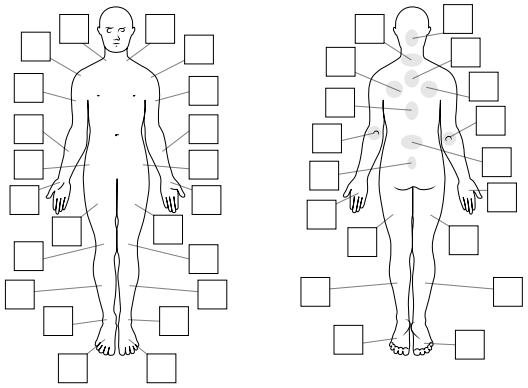
Translated by: _____

PATIENT NAME: _____ **DATE:** _____

Rate the level of pain you are experiencing on a scale of 1-10 (1 minimum - 10 maximum)

○ ○ ○ ○ ○ ○ ○ ○ ○ ○
1 2 3 4 5 6 7 8 9 10

Where are you having your pain?
Please indicate a P for pain, N for numbness and T for tingling.



How did your pain begin? ○Suddenly ○Gradually

Is your pain constant? ○Yes ○No

Do you have any existing pain/symptoms from a previous incident? ○Yes ○No

Have you ever had similar symptoms? ○Yes ○No

When? _____

Treatment received: _____

_____

Are you currently working? ○Yes ○No

What activities can you no longer do as a result of this injury? _____

_____

Are you disabled as a result of this injury? ○Yes ○No

Medical History

Check any and all medical conditions that apply to you.

- ☐ High Blood Pressure
- ☐ Asthma/Lung Disease
- ☐ Heart Disease/Arrhythmia
- ☐ Arthritis
- ☐ HIV or Exposure
- ☐ Congestive Heart Failure
- ☐ Kidney or Liver Disease
- ☐ Pacemaker
- ☐ Head Injury
- ☐ Spinal Injury
- ☐ Spinal Surgery
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Gastritis or Ulcers
- ☐ Cancer
- ☐ Stroke/Seizure
- ☐ High Cholesterol
- ☐ Other

Past Surgical History

Please list any surgeries you've had and approximate dates.

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

Please fill out this shaded section ONLY if you were involved in an automobile accident.

Date of accident: ___/___/___

Time: _____ ○AM ○PM

Location: _____

Did you have a seat belt on? ○Yes ○No

Were you the: ○Driver ○Front Seat Passenger ○Rear Passenger: Left ○Pedestrian ○Rear Passenger: Middle ○Bicyclist ○Rear Passenger: Right ○Motor Cyclist

Type of impact: ○Head On ○Rear End ○Left Side ○Right Side

Auto Insurance Company: _____

Claim Number: _____

Policy Number: _____

Did any part of your body impact anything inside the car? ○Yes ○No

If yes, describe: _____

Did you lose consciousness? ○Yes ○No

Did you go to the hospital? ○Yes ○No

How did you get to the hospital?

_____

What was done at the hospital?

_____

Do you have an attorney? ○Yes ○No

Attorney Name: _____

Attorney Phone Number: _____

Family History Place an “x” in appropriate boxes to identify all illnesses/conditions in your blood relatives.

Illness/Condition	Family Member							
	Grandparents	Father	Mother	Brother	Sister	Son	Daughter	Other
Colon or Rectal Cancer								
Other Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Liver Disease								
High Cholesterol								
Alcohol/Drug Abuse								
Depression/Psychiatric Illness								
Genetic (inherited) Disorder								
Stroke								
Other								

Medications

Prescription Medications	Dosage Strength	How Often Taken

Non-Prescription (List over the counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Non-Prescription Medications	Dosage Strength	How Often Taken

PATIENT NAME: _____ **DATE:** _____