KINETIC
CHIROPRACTIC + SPORTS PERFORMANCE

Patient General Information Questionnaire

First Name _____ Last Name _____ M.I. _____

Preferred to be called _____ Date of Birth ___/___/_____ [ ] M [ ] F

Patient or Guardian's Name (if a minor) _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: [ ] Home [ ] Cell _____

Email: _____

Occupation: _____

Are you, or is there any chance you may be pregnant? **[ ] Yes [ ] No [ ] Not Sure [ ] N/A**

Marital Status: [ ] Single [ ] Married [ ] Widowed

Emergency Contact: _____ Relationship: [ ] Parent [ ] Spouse [ ] Friend/Other

Emergency Contact Phone #: _____

Whom may we thank for referring you to us? _____

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Are you here for a specific condition? **[ ] Yes [ ] No** ***If No, please go directly to the next page.***

Chief Complaint 1: _____

- **Briefly describe the complaint:** _____
- **Pain Scale:** (Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
- **How does the pain feel?** [ ] Sharp [ ] Dull [ ] Ache [ ] Sore/Stiff [ ] Numb/Tingling [ ] Pinching [ ] Tightness/Spasm [ ] Burning
- **Timing:** [ ] Constant (75-100% of time) [ ] Comes & Goes (50-75% of time) [ ] Once in awhile (<50% of the time)
- **How long have you had this problem?** _____ Have you had this or something similar before? [ ] Yes [ ] No
- **Check all that aggravate your condition:**

[ ] Driving [ ] Walking [ ] Sitting [ ] Standing [ ] Lying Down [ ] Exercising [ ] Lifting Objects
[ ] Coughing/Sneezing/Straining [ ] Bowel Movements [ ] Breathing/Deep Breaths [ ] Nothing
[ ] Other: _____

- **Check all that make your condition better:**

[ ] Resting [ ] Stretching [ ] Sitting [ ] Standing [ ] Lying down [ ] Walking [ ] Exercising [ ] Massage
[ ] Chiropractic [ ] Medication [ ] Nothing

- **Have you seen any other healthcare provider for your current condition? [ ] Yes [ ] No**

Chief Complaint 2: _____

- **Briefly describe the complaint:** _____
- **Pain Scale:** (Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)
- **How does the pain feel?** [ ] Sharp [ ] Dull [ ] Ache [ ] Sore/Stiff [ ] Numb/Tingling [ ] Pinching [ ] Tightness/Spasm [ ] Burning
- **Timing:** [ ] Constant (75-100% of time) [ ] Comes & Goes (50-75% of time) [ ] Once in awhile (<50% of the time)
- **How long have you had this problem?** _____ Have you had this or something similar before? [ ] Yes [ ] No
- **Check all that aggravate your condition:**

[ ] Driving [ ] Walking [ ] Sitting [ ] Standing [ ] Lying Down [ ] Exercising [ ] Lifting Objects
[ ] Coughing/Sneezing/Straining [ ] Bowel Movements [ ] Breathing/Deep Breaths [ ] Nothing
[ ] Other: _____

- **Check all that make your condition better:**

[ ] Resting [ ] Stretching [ ] Sitting [ ] Standing [ ] Lying down [ ] Walking [ ] Exercising [ ] Massage
[ ] Chiropractic [ ] Medication [ ] Nothing

- **Have you seen any other healthcare provider for your current condition? [ ] Yes [ ] No**

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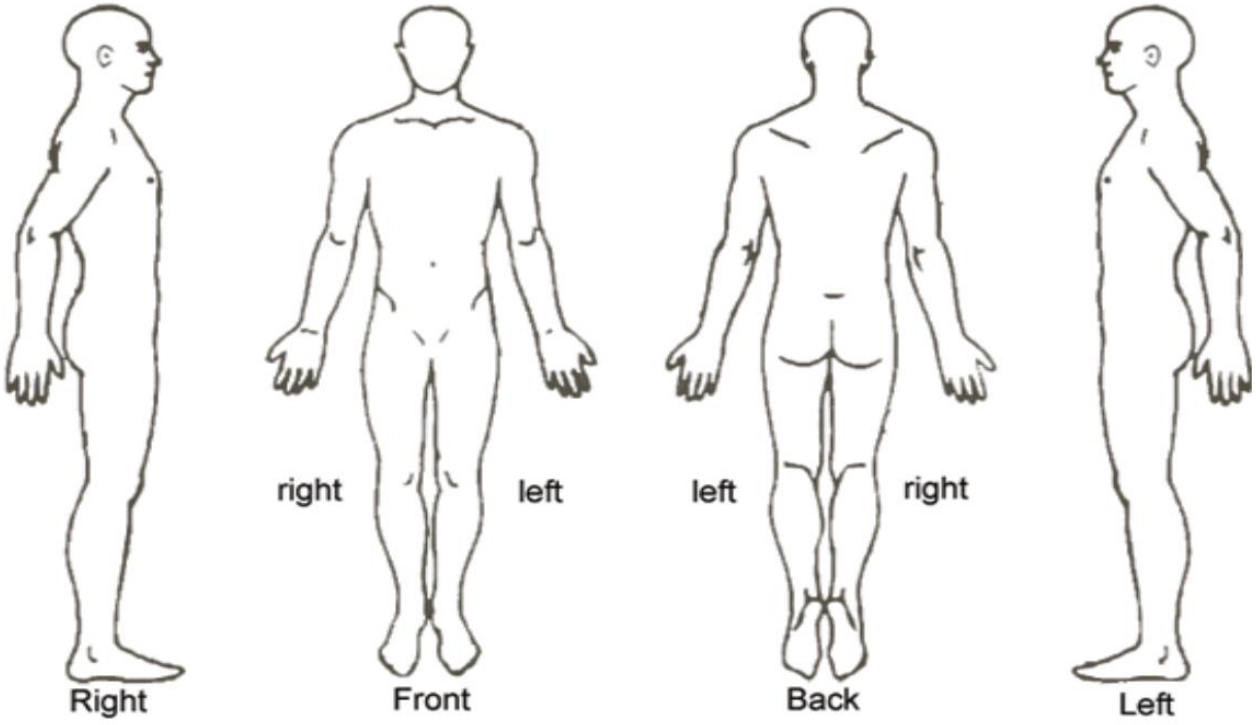
Please mark the areas of your condition below:



S=Sharp, A=Ache, N=Numb, B=Burning, P=Pinch

Review of Systems

Please check all that you currently have or have had in the past. C=Current P=Past

Muscle/Joint	**ERT/Internal/Dig-estive**	**Cardiovascular** C P	**Pulmonary** C P	**General**
Arthritis C P	Thyroid C P	Blood Pressure C P	C.O.P.D. C P	Food Allergy C P
Back Pain C P	Hearing C P	Irregular HR C P	Asthma C P	Dizziness C P
Sciatic Pain C P	Vision C P	Poor Circulation C P	Seasonal Allergy C P	**Infectious Disease**
Hip Pain C P	Ear Infection C P	**Urinary/Reproductive**	**Skin**	HIV C P
Foot Pain C P	Stomach C P	UTI C P	Psoriasis C P	Hepatitis C P
Neck Pain C P	Intestinal C P	Prostate C P	Varicose C P	TB C P
Headache C P	Colon C P	Kidney C P	Skin Allergy C P	**Endocrine** C P
Shoulder Pain C P	Liver C P	Pregnancy C P	Hives C P	**Neurological** C P
Arm Pain C P	Gall Bladder C P	Menstrual C P	Easy Bruising C P	**Psychological** C P
Wrist Pain C P	Pancreas C P	Venereal Disease C P		
		Difficulty Urinating C P		

Are you taking any medications and/or supplements? If YES, please list:

_____
_____

Past Health History:

- Accidents (Car Accidents) , Injuries, Falls, Fractures (Dates): _____

  _____

- Hospitalizations, Surgeries (Dates): _____

  _____

Family History of any health conditions (Heart disease, cancer, diabetes, etc): _____

_____

_____

Life Style:

- Do you drink? [ ] Yes [ ] No If YES, how many glasses per day or per week? _____
- Do you smoke? [ ] Yes [ ] No If YES, how many packs per week, and for how long? _____
- Do you exercise? [ ] Yes [ ] No If YES, how often? _____
  - Type of exercise (circle all that apply):

    Stretching/Flexibility Running/Jogging/Walking Swimming/Rowing
    Competitive Athlete Weight Lifting HIIT Biking Other:_____

- Sleep Quality/Hours: [ ] Excellent [ ] Good [ ] Poor _____ Hours/night
- *Do you have any specific physical or functional goal(s) that you'd like to accomplish?*

  _____
  _____
  _____
  _____

Consent for Chiropractic Care at Kinetic Chiropractic + Sports Performance

Chiropractic care is based on clinical evidence of vertebral subluxations, and its effects, and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal and/or extremity adjustments, the goals of chiropractic care is primarily to reduce and/or correct aforementioned subluxations.

- *In some situations, your care may occur in an open environment and personal health information (PHI) may be subject to incidental exposure by others in the clinic setting. I understand and consent to be treated in such environment.*
- *I authorize **Kinetic Chiropractic + Sports Performance** and its agents to administer exam and care as needed, as indicated from examination findings. I authorize **Kinetic Chiropractic + Sports Performance** to release information to my doctor and/or insurance company upon my request. A photocopy of this document shall be considered as effective and valid as the original.*
- *A parent or an approved individual MUST accompany their minor/child on every visit to the clinic.*
- *I acknowledge that I have read **Kinetic Chiropractic + Sports Performance Notice of Privacy Practices** and acknowledge that I may have a personal copy of the entire notice upon request.*
- *I consent to the use and/or disclosure of my PHI as specified in **Kinetic Chiropractic + Sports Performance Notice of Privacy Practices**.*
- *I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.*
- *I understand that intentionally providing false insurance information may be considered as fraud. I am fully aware that having health insurance does not release me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company. I hereby authorize **Kinetic Chiropractic + Sports Performance** to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided, in good faith. I fully agree and understand that the submission of a claim does not release me of my responsibility to ensure that the claim is paid in full.*

I have read and understand all the above.

_____	_____	_____
Patient Signature	**Relationship to Patient**	**Date**

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Notice of Privacy Practice

This office is required to notify you, 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. Once you have read this notice, please sign the last page.

Permitted Disclosures:

- Treatment purposes – discussion with other health care providers involved in your care.
- Inadvertent disclosures – open treating areas 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.
- For payment purposes – to obtain payment from your insurance company or any available collateral source.
- For worker's compensation purposes – to process a claim or aid in investigation
- Emergency – in the event of a medical emergency we may notify a family member
- Public health and safety – in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
- Government or Law Enforcement – to identify or locate a suspect, fugitive, or material witness or missing persons.
- For military, national security, prisoner, and government benefits purposes.
- Deceased persons – discussion with coroners and medical examiners in the event of your death.
- Telephone calls, emails, or appointment reminders – we may call your home to remind you of a missed appointment or leave messages when necessary concerning events or clinic hours.
- Change of ownership – in the event of new ownership.

Notice of Privacy Practice [continued] …

Your Rights:

- To receive an accounting of disclosures.
- To receive a paper copy of this notice.
- To request mailings to an address different than residence.
- To request restrictions on certain uses and disclosures and with whom we release information to.
- To inspect your records and receive one copy of your records at no charge, with notice in advance.
- To request amendments to information, however like restrictions, we are not required to agree to them.

Complaints:

If you wish to make a formal complaint about how we handle your health information please call Dr. Zachary Bohm, DC at 732-759-4577. If Dr. Bohm is unavailable, you may make an appointment by calling the office to see him within 2 business days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

Division of Consumer Affairs

State Board of Chiropractic Examiners

124 Halsey St., 6th Floor, Newark, NJ 07102

Note: This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains, past and present.

I have received a copy of Kinetic Chiropractic + Sports Performance Patient Privacy Notice and understand my rights as well as the *practices* and duties to protect my personal health information and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Signature **Date**

_____

Patient Name (Print)