NJ Spine & Joint
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CONFIDENTIAL
HEALTH INFORMATION

All information you supply is confidential.
We comply with all federal privacy standards.

Please print clearly.

GENERAL

Today's Date (MM/DD/YYYY) ____ How did you hear about us? ____

First Name ____ Middle Name ____ Last Name ____ Gender (M) (F)

Birth Date (MM/DD/YYYY) ____ Age ____ Race ____ Ethnicity ____ Preferred Language ____

Address ____ City ____ State ____ Zip ____

Email Address ____ Phone Number ____ Phone Type (Cell) (Work) (Home)

Emergency Contact ____ Emergency Contact's Phone ____

FAMILY

Marital Status (Single) (Married) (Divorced) (Widowed) (Separated)

Spouse's Name ____

Child's Name & Age ____ Child's Name & Age ____ Child's Name & Age ____

EMPLOYMENT

Occupation ____ Employer ____

Address ____ City ____ State ____ Zip ____

INSURANCE

Insurance Carrier ____ Policy Number ____ Who carries this policy? (Self) (Spouse) (Parent)

Insured's First Name ____ Insured's Middle Name ____ Insured's Last Name ____ Birth Date (MM/DD/YYYY) ____

Insured's Employer ____ Employer's Phone ____

Employer's Address ____ City ____ State ____ Zip ____

MAIN SYMPTOMS

1. Please explain your main symptoms and/or complaints.

____

____

____

2. Symptoms are the result of:

- ☐ Auto Accident ☐ Work Injury
- ☐ Gradual Onset ☐ Worsening Long-Term Problem
- ☐ Other ______________________________

3. When did you first notice your current symptoms?

____

4. Intensity (Scale 1-10)

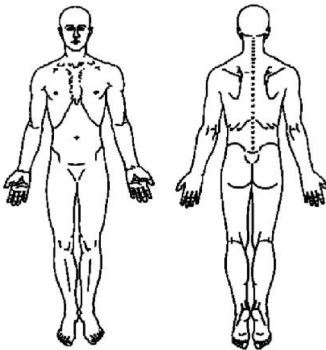
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. Duration & Timing ☐ Constant ☐ On and Off - How frequent? ______________________________

6. Quality of Symptoms

☐ Numbness	☐ Sharp	☐ Aching	☐ Nagging	☐ Burning	☐ Throbbing	☐ Other ________
☐ Tingling	☐ Dull Ache	☐ Cramps	☐ Stiffness	☐ Shooting	☐ Stabbing	________

7. Location - Where does it hurt?
Circle the areas on the illustration.



8. Radiation - Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel? ______________________________

____

9. Aggravating or Relieving Factors
What makes it better or worse, such as time of day, movements, etc.? ______________________________

____

10. How does your current condition interfere with your:

- Employment or Career ______________________________
- Activities or Hobbies ______________________________
- Personal Relationships ______________________________
- Household Responsibilities ______________________________

DAILY ACTIVITIES

What effect does your current condition have on your life and ability to function?

	None	Mild	Moderate	Severe
Sitting	☐	☐	☐	☐
Getting Out of Chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Bending Over	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Falling Asleep	☐	☐	☐	☐
Staying Asleep	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Getting In & Out of Car	☐	☐	☐	☐
Looking Over Shoulder	☐	☐	☐	☐

	None	Mild	Moderate	Severe
Using a Computer	☐	☐	☐	☐
Lifting Objects	☐	☐	☐	☐
Grocery Shopping	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Caring for Family	☐	☐	☐	☐
Showering or Bathing	☐	☐	☐	☐
Getting Dressed	☐	☐	☐	☐
Love Life	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Reaching Overhead	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐

Preferred Sleeping Position ______________________________ Hours of Sleep Per Night ______________

	Never	Rarely	1x/Week	2-3x/Week	4-5x/Week	6-7x/Week
Frequency of Exercise	☐	☐	☐	☐	☐	☐

Type of Exercise ______________

CONDITIONS

Please indicate any condition that you've previously **had** or currently **have**.

Musculoskeletal
Had Have
- ☐ ☐ Neck Pain
- ☐ ☐ Shoulder Pain
- ☐ ☐ Elbow Pain
- ☐ ☐ Arm Pain
- ☐ ☐ Wrist/Hand Pain
- ☐ ☐ Back Pain
- ☐ ☐ Hip Pain
- ☐ ☐ Knee Pain
- ☐ ☐ Leg Pain
- ☐ ☐ Ankle/Foot Pain
- ☐ ☐ Arthritis
- ☐ ☐ Osteoporosis

Skin
Had Have
- ☐ ☐ Skin Cancer
- ☐ ☐ Psoriasis
- ☐ ☐ Eczema
- ☐ ☐ Rash

Neurological
Had Have
- ☐ ☐ Headaches
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Dizziness
- ☐ ☐ Pins & Needles
- ☐ ☐ Numbness
- ☐ ☐ Tingling
- ☐ ☐ Shingles
- ☐ ☐ Epilepsy
- ☐ ☐ Multiple Sclerosis

Constitutional
Had Have
- ☐ ☐ Fainting
- ☐ ☐ Fatigue
- ☐ ☐ Weakness
- ☐ ☐ Poor Appetite
- ☐ ☐ Low Libido
- ☐ ☐ Sudden Weight Gain or Loss

Cardiovascular
Had Have
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Poor Circulation
- ☐ ☐ Excessive Burning
- ☐ ☐ Heart Disease
- ☐ ☐ Stroke
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Angina

Genitourinary
Had Have
- ☐ ☐ Kidney Stones
- ☐ ☐ Infertility
- ☐ ☐ Bedwetting
- ☐ ☐ Prostate Issues
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ PMS Symptoms
- ☐ ☐ STDs

Digestive
Had Have
- ☐ ☐ Anorexia
- ☐ ☐ Bulimia
- ☐ ☐ Ulcer
- ☐ ☐ Food Sensitivities
- ☐ ☐ Heartburn
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Hepatitis

Endocrine
Had Have
- ☐ ☐ Thyroid Issues
- ☐ ☐ Goiter
- ☐ ☐ Immune Disorders
- ☐ ☐ Hypoglycemia
- ☐ ☐ Frequent Infection
- ☐ ☐ Swollen Glands
- ☐ ☐ Low Energy
- ☐ ☐ Diabetes

Respiratory
Had Have
- ☐ ☐ Asthma
- ☐ ☐ Apnea
- ☐ ☐ Emphysema
- ☐ ☐ Hay Fever
- ☐ ☐ Shortness of Breath
- ☐ ☐ Pneumonia
- ☐ ☐ Allergies

Sensory
Had Have
- ☐ ☐ Blurred Vision
- ☐ ☐ Glaucoma
- ☐ ☐ Ringing In Ears
- ☐ ☐ Hearing Loss
- ☐ ☐ Loss of Taste
- ☐ ☐ Loss of Smell
- ☐ ☐ Chronic Ear Infection

ILLNESSES

Please indicate any illnesses or other conditions you have **had** or currently **have**.

Had Have
- ☐ ☐ Gout
- ☐ ☐ Cancer
- ☐ ☐ Polio
- ☐ ☐ Chicken Pox
- ☐ ☐ Mumps
- ☐ ☐ Measles
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Scarlet Fever
- ☐ ☐ Typhoid Fever
- ☐ ☐ Tuberculosis
- ☐ ☐ AIDS
- ☐ ☐ HIV Positive
- ☐ ☐ Alcoholism
- ☐ ☐ Other ______________

____

SURGERIES

Please indicate any surgeries or operations you have had.

- ☐ Cancer
- ☐ Neck
- ☐ Back
- ☐ Shoulder
- ☐ Hip
- ☐ Hip Replacement
- ☐ Knee (Arthroscopic)
- ☐ Knee Replacement
- ☐ Heart
- ☐ Pacemaker
- ☐ Eye
- ☐ Cosmetic
- ☐ Vasectomy
- ☐ Hysterectomy
- ☐ Appendix Removal
- ☐ Tonsillectomy
- ☐ Bypass
- ☐ Other

____

____

TREATMENTS

Please indicate any treatments that you've had or are receiving.

Past Now
- ☐ ☐ Acupuncture
- ☐ ☐ Antibiotics
- ☐ ☐ Birth Control Pills
- ☐ ☐ Blood Transfusions
- ☐ ☐ Chemotherapy
- ☐ ☐ Chiropractic Care
- ☐ ☐ Dialysis
- ☐ ☐ Homeopathy
- ☐ ☐ Hormone Replacement
- ☐ ☐ Inhaler
- ☐ ☐ Massage Therapy
- ☐ ☐ Physical Therapy
- ☐ ☐ Vitamins ______________

____
- ☐ ☐ Medications ______________

____

HABITS & SOCIAL

	How Often?		**How Often?**
Alcohol	______________	Coffee	______________
Tobacco	______________	Soft Drinks	______________
Drugs	______________	Water	______________
Pain Relievers	______________	Exercise	______________

Hobbies ______________

What is the major stressor in your life? ______________

FAMILY HISTORY

Relative	Age (If Living)	Health: Good	Health: Poor	Diseases or Illnesses	Age of Death	Cause of Death: Natural	Cause of Death: Illness
Mother	______	☐	☐	______	______	☐	☐
Father	______	☐	☐	______	______	☐	☐
Sister	______	☐	☐	______	______	☐	☐
Sister	______	☐	☐	______	______	☐	☐
Brother	______	☐	☐	______	______	☐	☐
Brother	______	☐	☐	______	______	☐	☐
______	______	☐	☐	______	______	☐	☐

Other known hereditary health issues: ______

GOALS

What would be the most significant thing that you could do to improve your health? ______

______

In addition to the main reason for your visit today, what additional health goals do you have? ______

______

AGREEMENT

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

______ Initials — I request and consent to the performance of medical procedures, including, but not limited to, various modes of physical therapy, chiropractic, medical massage, cold laser therapy, injections, intravenous drips, platelet-rich plasma therapy, stem cell therapy, cosmetic treatments and procedures, and diagnostic x-rays and testing, on me by the doctors and/or clinical staff of NJ Spine & Joint.

______ Initials — I understand and am informed that, as in the practice of medicine and chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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.

______ Initials — I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period: ____________.

______ Initials — I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services that I receive.

______ Initials — To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

______ Signature

______ Date (MM/DD/YYYY)