Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

NAME ______________________ DATE __________ HOME PHONE __________

ADDRESS ______________________ CITY __________ STATE __________ ZIP __________ WORK PHONE __________

DATE OF BIRTH __________ AGE ______ M ______ F ______ MARITAL STATUS __________ NO. CHILDREN __________

OCCUPATION ______________________ SS # __________ SPOUSE __________

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ______________________ REFERRED BY __________

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O - OCCASIONAL
F - FREQUENT
C - CONSTANT

O F C

GENERAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fatigue
☐ ☐ ☐ Fever
☐ ☐ ☐ Headache
☐ ☐ ☐ Loss of sleep
☐ ☐ ☐ Loss of weight
☐ ☐ ☐ Nervousness/depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low back pain
☐ ☐ ☐ Lumbago
☐ ☐ ☐ Neck pain or stiffness
☐ ☐ ☐ Pain between shoulders

Pain or numbness in:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Elbows
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful tail bone
☐ ☐ ☐ Poor posture
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Spinal curvature
☐ ☐ ☐ Swollen joints

O F C

GASTRO-INTESTINAL

☐ ☐ ☐ Belching or gas
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult digestion
☐ ☐ ☐ Distension of abdomen
☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Gall bladder trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Liver trouble
☐ ☐ ☐ Nausea
☐ ☐ ☐ Pain over stomach
☐ ☐ ☐ Poor appetite
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomiting of blood

EYES, EARS, NOSE & THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental decay
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noises
☐ ☐ ☐ Enlarged glands
☐ ☐ ☐ Enlarged thyroid
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Failing vision
☐ ☐ ☐ Far sightedness
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Near sightedness
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection
☐ ☐ ☐ Sore throat
☐ ☐ ☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

RESPIRATORY

☐ ☐ ☐ Chest pain
☐ ☐ ☐ Chronic cough
☐ ☐ ☐ Difficult breathing
☐ ☐ ☐ Spitting up blood
☐ ☐ ☐ Spitting up phlegm
☐ ☐ ☐ Wheezing

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin eruptions (rash)
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Inability to control kidneys
☐ ☐ ☐ Kidney infection or stones
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostate trouble
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Congested breasts
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Excessive menstrual flow
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Painful menstruation
☐ ☐ ☐ Vaginal discharge
☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Cancer
☐ Chorea
☐ Cold sores
☐ Diabetes
☐ Diphtheria
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fever blisters
☐ Goiter
☐ Gout
☐ Heart disease
☐ Influenza
☐ Lumbago
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Stroke
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping cough

Have you ever had previous chiropractic care? __________ If yes, date of last care __________

Do you have Health and Accident Insurance? __________ If yes, with what company? __________

Is this an Industrial Accident Case? ☐ Yes ☐ No

CONFIDENTIAL PATIENT CASE HISTORY

PLEASE PRINT

What is your major complaint? ______________________________

____

Other complaints ______________________________

How long have you had this condition? ______________ Have you had this or similar conditions in the past? ______________

What activities aggravate your condition? ______________________________

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine Other ______________

How long has it been since you really felt good? ______________________________

List previous diagnoses and treatments you have received for present condition ______________

____

What do you believe is wrong with you? ______________________________

List surgical operations and years: ______________________________

____

Drugs you now take: ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ "Pep" pills ☐ Tranquilizers ☐ Birth control pills

Others ______________________________

Dental visits: ☐ Every six months ☐ Yearly ☐ Toothache or emergency only ☐ Complete dentures

Age of mattress ______________ ☐ Comfortable ☐ Uncomfortable Do you use a bed board: ______________

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

Have you been in an auto accident: ☐ Past year ☐ Past five years ☐ Over five years ☐ Never

Describe ______________________________

Have you ever had any mental or emotional disorders? ☐ Yes ☐ No When? ______________

Have others in your family had such disorders? ☐ Yes ☐ No When? ______________

FAMILY HEALTH INFORMATION (Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better picture of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	
Used a cane, crutch, or other support?	☐	☐	
Been treated for a spine or nerve disorder?	☐	☐	
Had a fractured bone?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	
DO YOU:			
Now take vitamins or minerals?	☐	☐	
Think you may need vitamins or minerals?	☐	☐	
Have an allergy to any drug?	☐	☐	

DATE OF LAST:	Less than 6 months	6-18 months	Over 18 months	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

LIST BELOW ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE PAST 10 YEARS.

____

____

____

____

____

____

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME ______________________________

ADDRESS ______________________________ PHONE ______________

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Form No. 104

AUTHORIZATION & ASSIGNMENT

TO: Dr. Robert M. Monahan, D.C.

In consideration of your undertaking to treat me, I agree to the following:

RELEASE OF INFORMATION

You are authorized to release any information you deem necessary and appropriate concerning my condition, to any insurance carrier, attorney or adjuster, in order to process any claim for reimbursement of charges incurred at your facility by me.

AUTHORITY TO PAY DOCTOR

I authorize the direct payment to you, of any sum I now or hereafter may owe you, be either my carrier or my attorney, out of the proceeds of any settlement of my case, or for which my insurance carrier has been billed, or otherwise obligated to make payment either to me or to you, based in whole or in part on the charges made for your services.

IRREVOCABLE ASSIGNMENT

I authorize you to compromise, settle or otherwise resolve said claim as you see fit. I further agree that the foregoing assignment shall be binding until you are paid in full and will be irrevocable for such period. I further agree to grant you my full and complete permission to endorse any check from my carrier, payable to me, with a facsimile of my signature.

PATIENT RESPONSIBLE FOR BALANCE

I understand that I am personally liable for any amount owed after reasonable efforts have been made to collect from any carrier so obligated.

Date: ______________________ Signed: ________________________________

FORT LEE HEALTH CENTER, INC.

Dr. Robert M. Monahan, D.C.

1067 Palisade Avenue, Fort Lee, NJ 07024

Patient Privacy Policy & Procedure Statement

(HIPAA)

Dear Patient:

Fort Lee Health Center, Inc. maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent, to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical records and access history by signing a letter for release of your medical information. The cost for copies and of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 201-886-8184.

Fort Lee Health Center, Inc. reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations and guidelines.

THANK YOU FOR CHOOSING FORT LEE HEALTH CENTER, INC. FOR YOUR HEALTHCARE!!

Signature:______________________________ Date:____________________

VERIFICATION OF INSURANCE COVERAGE

**** THIS OFFICE IS NOT RESPONSIBLE TO VERIFY BENEFITS ****

Please contact your insurance company to obtain your chiropractic benefits and coverage.

Date:____

Name of Insured:____

Name of Patient:____

Insurance Company Policy #:_______________Group #:____________

Insurance Company:______________________________________

Address:____

Insured's Employer:______________________________________

This is to verify coverage, as stated in our telephone conversation of _______

When I spoke to ___________________ Coverage was stated, as follows:

Amount of deductible:_____________________________________

Individual:______________________ Family:__________________

Has the deductible been met?:________________________________

Co-insurance responsibility:_________________________________

Co-payment responsibility:__________________________________

Maximum number of visits allowed per year______________________

Contract Year or Calendar Year?______________________________

Reference Number for the call:_______________________________

Date:___________________ Signature:_____________________