NJ GONSTEAD
Chiropractic

ABOUT YOU

Patient Name____________________ Date__________

What do you prefer to be called?____________________

☐ Male ☐ Female

Birth Date____________________ Age__________

Mailing Address____________________

Home Phone____________________ Work Phone____________________

Cell Phone____________________ Email____________________

Referred by____________________

Employer____________________ How long?__________

Employer's Address____________________

Occupation____________________

Status: ☐ Minor ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Widow/Widower

Partner's Name____________________

How many children do you have?____________________ Ages__________

INSURANCE INFO

Carrier Name ____________________

Note: If you have insurance, please bring your card.

REASON FOR VISIT

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic

Explain____________________

Please describe pain and its location____________________

When did condition begin?____________________

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

Is this condition interfering with your : ☐ Work ☐ Sleep ☐ Daily Routine

If so, please explain____________________

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain____________________

Have you been treated for this condition? ☐ Yes ☐ No

If yes, by whom? ☐ DC ☐ MD ☐ Lac ☐ DO ☐ ND ☐ Other ____________________

What is your physical activity at work?____________________

Do you exercise? ☐ No ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-7 times/week

Type of exercise? ☐ Cardiovascular ☐ Stretching ☐ Strengthening ☐ Type of sports

What is your present general stress level? ☐ None ☐ Minimal ☐ Moderate ☐ Greatly stressed

Is your current condition affecting your ability to work or do other routine daily activities? ☐ Yes ☐ No

If so, please explain____________________

IN THE EVENT OF EMERGENCY

Who should we contact?____________________ Relation__________

Home Phone____________________ Work Phone____________________

Who is your medical doctor?____________________ Phone__________

PAST OR PRESENT SYMPTOMS, CONDITIONS OR HABITS

Symptoms	Past	Present	Symptoms	Past	Present	Symptoms	Past	Present
Neck pain	☐	☐	Shoulder pain	☐	☐	Arm pain	☐	☐
Hand pain	☐	☐	Upper back pain	☐	☐	Lower back pain	☐	☐
Hip pain	☐	☐	Knee pain	☐	☐	Ankle pain	☐	☐
Foot pain	☐	☐	Jaw pain	☐	☐	Stiffness	☐	☐
Headaches	☐	☐	Dizziness	☐	☐	Fainting	☐	☐
Convulsions	☐	☐	Fatigue	☐	☐	High blood pressure	☐	☐
Heart Condition	☐	☐	Respiratory	☐	☐	Digestive	☐	☐
Kidney	☐	☐	Bladder	☐	☐	Sinus	☐	☐
Allergies	☐	☐	Asthma	☐	☐	Cancer	☐	☐
Stroke	☐	☐	Skin Condition	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Prostate	☐	☐	Uterus	☐	☐
Ovaries	☐	☐	Menstrual	☐	☐	Breast Soreness	☐	☐

Habits	Past	Present	Occasional	Moderate	Heavy
Tobacco use	☐	☐	☐	☐	☐
Alcohol use	☐	☐	☐	☐	☐
Caffeine use	☐	☐	☐	☐	☐

Conditions	Past	Present
Pregnancy	☐	☐
Surgery	☐	☐

Please list ______________________

As part of the new Obama Care electronic health records (EHR) program, Meaningful Use, we are now required to have the following information up to date in our system. As always this is confidential.

Name____DOB________________

What medications are you taking?____

Do you have allergies to any medications? ☐ Yes ☐ No

If yes, please list: ____

What is the allergic reaction?____

What is your preferred language? ☐ English Other__________________________________

What is your race?

☐ White ☐ African American ☐ Other race ☐ Unknown ☐ Asian ☐ More than one race

☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

What is your ethnicity? ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Do you smoke cigarettes? ☐ Yes ☐ No If so, how many per day?_____Quit? (When?)_____

MEDICINE TAKEN

Nerve Pills	☐
Pain killers (include Aspirin)	☐
Muscle relaxers	☐
Stimulants	☐
Blood thinners	☐
Tranquilizers	☐
Insulin	☐

Other

____

____

OBJECTIVE

My primary cause in being seen at Clinic is :

Specific injury	☐
Sports performance Enhancement	☐
Wellness/Prevention	☐

My primary Goal in being seen at Clinic is :

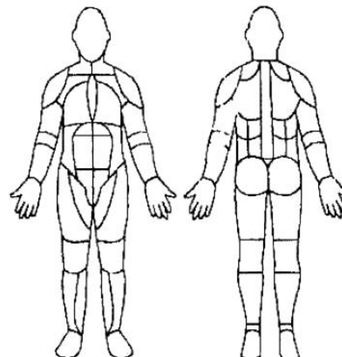
Reduced pain	☐
Improved function	☐
Wellness/Prevention	☐

Signature ________________________________

Date ________________________________

PAIN & SYMPTOMS CHART

Shade in the area you have pain or other symptoms



FAMILY HISTORY

Please indicate if a close family member has had any one of the following diseases:

Symptoms	Past	Present
Alcoholism	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Epilepsy	☐	☐
Pneumonia	☐	☐
Diabetes	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Cancer	☐	☐
Headache	☐	☐
Thyroid	☐	☐
Gout	☐	☐
Kidney	☐	☐
Liver	☐	☐

Other ______________________

FOR DOCTORS USE ONLY

I have reviewed the information contained on this form with the patient.

Provider initials____________________________Date________________

Patient Name: ________________________ No. _____________

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of a disc condition, and although extremely rare; minor fractures, and possible stroke (which occurs at a rate between one instance per one million, to one per two million) have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at NJ Gonstead Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_________________________________ ___________

Patient or Authorized Person's Signature Date

WRITTEN CONSENT FOR A MINOR/CHILD

Name of practice member who is a minor/child ___________________

I authorize Dr. Jeongho Yoo and any all NJ Gonstead Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustment and supportive therapy to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify NJ Gonstead Chiropractic.

_________________________________ ________________________

Guardian's Name Date

_________________________________ ________________________

Guardian's Signature Guardian Relationship

ASSIGNMENT OF BENEFITS

I hereby authorize payment to be made directly to NJ Gonstead Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to NJ Gonstead Chiropractic for any and all services I receive at this office.

_________________________________ ________________

Patient or Authorized Person's Signature Date

Patient Name: ________________________ No. _____________

Patient Consent to X-Ray

I understand the doctor may feel that x-rays will be needed in order to diagnose my condition and administer treatment. I authorize diagnostic x-rays to be performed by the doctor who is Jeongho Yoo, DC at NJ Gonstead Chiropractic. At this time I know of no other condition which the taking of x-rays would further complicate.

_________________________________ ___________
Patient or Authorized Person's Signature Date

Consent to X-Ray A Minor

I am a parent or legal guardian of __________________________, who is a minor, ________ years of age. I understand the doctor may feel that x-rays will be needed in order to diagnose and treat the patient. As the parent or guardian of the patient, I authorize the performance of diagnostic x-rays by the doctor who is Jeongho Yoo, DC at NJ Gonstead Chiropractic on the above named minor. At this time I know of no other condition which the taking of x-rays would further complicate.

_________________________________ _______________________
Guardian's Name Date

_________________________________ _______________________
Guardian's Signature Guardian Relationship

Female Consent: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant. The doctor has my permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be harmful to an unborn fetus.

_________________________________ ___________
Patient or Authorized Person's Signature Date

Patient Name: ________________________ No. _____________

MEDICAL INFORMATION RELEASE FORM (HIPAA RELEASE)

Name: ____ Date of Birth: __________________

A. Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ___________________
[ ] Child(ren) ___________________
[ ] Other _________________________
[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

B. Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________ If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] ____________________

_________________________________ ___________
Patient or Authorized Person's Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions

_________________________________ _________
Patient or Authorized Person's Signature Date

NJ GONSTEAD
Chiropractic

Patient Name: ________________________ No. _____________

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic. To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

_________________________________ __________

Patient or Authorized Person's Signature Date

NJ GONSTEAD
Chiropractic

Patient Name: ________________________ No. _____________

Missed Appointments and Late Cancellation Policy

Due to the busy nature of our practice, a scheduled appointment means that time is reserved only for you. We understand that sometimes it is necessary to reschedule appointments, therefore, please give us at least 24hours notice prior to canceling and we will gladly reschedule your appointment. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care.

- I understand that if I miss a scheduled chiropractic appointment or massage session, or cancel less than 24hours before the appointment, I am responsible for paying a $30.00 fee on my next visit.
- I understand that if I miss an appointment, without calling and rescheduling my appointment, I am responsible for the total cost of the appointment.
- I understand that if I miss a chiropractic appointment or massage session, without calling and rescheduling my appointment, I will be billed directly according to the scheduled fee or according to the rules of your health plan. Your health plan does not cover payment for missed appointment; therefore, you are responsible for full payment.
- I have been informed that reminder texts are made the day prior to my appointments as a courtesy but that I am expected to remember my appointment at the time I make that appointment. (Reminder texts are often made less than 24 hours before the schedule appointment time.)
- To cancel appointments please call 609-269-5491. If you do not reach the receptionist, you may leave a detailed message on the voice mail system 24 hours a day. We will call you to reschedule your appointment first thing the following business day. You may also cancel via email: njgonstead@gmail.com.

To better serve our patient, we enact this policy and we appreciate your understanding and are available to answer any questions you may have.

Patient Name (Please Print): ____

Patient Signature: ____________________________________ Date: _____________________