360 SPINE & SPORT CHIROPRACTIC CENTER

DEMOGRAPHIC INFORMATION

TODAY'S DATE:	DATE OF BIRTH:	SEX: MALE / FEMALE	
FIRST NAME:	LAST NAME:	M.I.:	
MARITAL STATUS: SINGLE / MARRIED / OTHER	EMAIL:		
CELL:	HOME:	WORK:	
OCCUPATION:	EMPLOYER:		
EMERGENCY CONTACT:	PHONE:	RELATION:	
HOW DID YOU HEAR ABOUT 360 HEALTH CENTER?			
ADDRESS: DOES IDENTIFICATION CARD PROVIDED LIST YOUR CURRENT ADDRESS? YES / NO (IF YES, SKIP BOX BELOW)			
ONLY COMPLETE IF NO WAS ANSWERED ABOVE.	ADDRESS:		
	CITY:	STATE:	ZIP:

ASSIGNMENT & FINANCIAL RESPONSIBILITY

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO AND MAILED DIRECTLY TO THIS CLINIC, THE PROFESSIONAL AND MEDICAL EXPENSE ALLOWABLE AND OTHERWISE PAYABLE UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGE FOR THE PROFESSIONAL SERVICES RENDERED BY THIS CLINIC. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS CLINIC INCLUDING ANY INSURANCE DEDUCTIBLE, CO-INSURANCE, AND ANY SERVICES REJECTED BY MY INSURANCE COMPANY.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I CONSENT TO 360 HEALTH CENTER ("THE PRACTICES") THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF PROVIDING TREATMENT TO ME, FOR PURPOSES RELATING TO THE PAYMENT OF SERVICES RENDERED TO ME, AND FOR THE PRACTICE'S GENERAL HEALTHCARE OPERATIONS AND PURPOSES. HEALTHCARE OPERATIONS PURPOSES SHALL INCLUDE, BUT NOT BE LIMITED TO, QUALITY ASSESSMENT ACTIVITIES, CREDENTIALING, BUSINESS MANAGEMENT AND OTHER GENERAL OPERATION ACTIVITIES. I UNDERSTAND THAT THE PRACTICE'S DIAGNOSIS OR TREATMENT OF ME MAY BE CONDITIONED UPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS DOCUMENT.

FOR PURPOSES OF THIS CONSENT, "PROTECTED HEALTH INFORMATION" MEANS ANY INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, CREATED OR RECEIVED BY THE PRACTICE, THAT RELATES TO MY PAST, PRESENT, OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION; THE PROVISION OF HEALTHCARE TO ME; OR THE PAST, PRESENT, OR FUTURE PAYMENT FOR THE PROVISION OF HEALTH CARE SERVICES TO ME; AND THAT EITHER IDENTIFIES ME OF FROM WHICH THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION CAN BE USED TO IDENTIFY ME.

I UNDERSTAND I HAVE A RIGHT TO REVIEW THE PRACTICE'S NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT. THE NOTICE OF PRIVACY PRACTICES DESCRIBES MY RIGHTS AND THE PRACTICE'S DUTIES REGARDING THE TYPES OF USES AND DISCLOSES OF MY PROTECTED HEALTH INFORMATION. I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT PHYSICIAN OR THE PRACTICE HAS ACTED IN RELIANCE TO THIS CONSENT.

RELEASE OF INFORMATION

I AUTHORIZE THIS CLINIC TO RELEASE PERTINENT INFORMATION TO ANY INSURANCE COMPANY, ADJUSTOR AND ATTORNEY (IF APPLICABLE) INVOLVED IN MY TREATMENT/CASE; AND HEREBY RELEASE THIS CLINIC OF ANY CONSEQUENCE.

ACKNOWLEDGMENTS OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED, REVIEWED, UNDERSTAND AND AGREE TO THE NOTICE OF PRIVACY PRACTICES OF 360 HEALTH CENTER LLC, WHICH DESCRIBES THE PRACTICE'S POLICIES AND PROCEDURES REGARDING THE USE DISCLOSURE OF ANY OF MY PROTECTED HEALTH INFORMATION CREATED, RECEIVED OR MAINTAINED BY THE PRACTICE.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

1235 Whitehorse-Mercerville Rd., Unit 318, Hamilton, NJ 08619
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360 SPINE & SPORT
CHIROPRACTIC CENTER

INFORMED CONSENT

Chiropractic, as well as many types of healthcare, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of healthcare delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or a disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Probabilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally, chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon or other soft tissue injury.

Osseous Injury- Manual adjustments to the skeletal system, in rare cases, may cause injury or fracture. Precautions such as pre-adjustment x-rays are taken in cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physiotherapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor or staff member.

Stroke- Stroke is the most serious of complications of chiropractic treatment. A study (Journal of the CAA, Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke in 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly. If you have any questions regarding this form or the above statements, please ask your doctor.

Having read the above, I hereby give my informed consent to have chiropractic treatment administered.

INSURANCE BENEFITS VERIFICATION

It is your responsibility to understand your insurance coverage. Your insurance benefits will be verified by 360 as a courtesy but we cannot guarantee accuracy or complete information. Final determination occurs when your visit is processed by your insurance company. We recommend contacting your insurance company with any questions in regards to your insurance coverage.

Patient Name: _____

Patient Signature: _____ Date: _____

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PROBLEM-FOCUSED HEALTH HISTORY

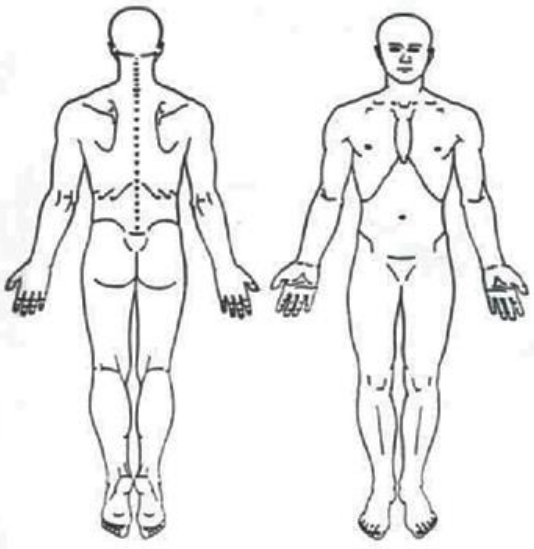
PATIENT NAME: _____ DATE: _____

SOCIAL/MEDICAL HISTORY:

1. ARE YOU CURRENTLY PREGNANT? ☐ N/A ☐ YES ☐ NO
2. DO YOU HAVE A PACEMAKER OR ICD: ☐ YES ☐ NO
3. IF YOU HAVE BEEN TO THIS CLINIC BEFORE, HAS THERE BEEN ANY CHANGES TO YOUR HEALTH HISTORY (DIAGNOSIS, SURGERY, ETC.) SINCE YOUR LAST VISIT? ☐ N/A ☐ YES ☐ NO
4. IS THIS CONDITION DUE TO AN ACCIDENT? ☐ YES ☐NO

☐ AUTO ☐ WORK ☐ HOME ☐ OTHER _____ DATE _____

5. PLEASE CIRCLE THE AREA(S) ON THE DIAGRAM WHERE SYMPTOMS ARE LOCATED.



6. MY CURRENT SYMPTOMS CAN BE DESCRIBED AS: (CHECK ALL THAT APPLY)

☐ ACHY	☐ SPASM	☐ BURNING	☐ ELECTRIC
☐ STIFF	☐ SHOOTING	☐ CRAMP	☐ GRIPING
☐ DEEP	☐ SHARP	☐ HEAVY	☐ THROBBING
☐ TIGHT	☐ STABBING	☐ TEARING	☐ POUNDING

7. WHEN DID YOUR SYMPTOMS BEGIN?

☐ 0-72 HOURS AGO	☐ 3-7 DAYS AGO
☐ 1-4 WEEKS AGO	☐ 1 -3 MONTHS AGO
☐ 3-6 MONTHS AGO	☐ 6-12 MONTHS AGO

☐ >12 MONTHS AGO

8. WHAT IS THE MOST LIKELY CAUSE OF YOUR SYMPTOMS?

_____

_____

_____

9. PLEASE CIRCLE YOUR PAIN/DISCOMFORT LEVEL AT ITS WORST AND CIRCLE YOUR PAIN/DISCOMFORT LEVEL AT ITS BEST.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

10. HOW OFTEN DO YOU EXPERIENCE PAIN THROUGHOUT THE DAY? CIRCLE YOUR ANSWER BELOW.

0% --- 25% --- 50% --- 75% --- 100%

11. MY CURRENT PAIN/INJURY MAKES THE FOLLOWING DIFFICULT/PAINFUL TO PERFORM: (CHECK ALL THAT APPLY)

☐ WALKING	☐ DRESSING	☐ LYING DOWN
☐ STANDING	☐ EXERCISE	☐ YARD WORK
☐ BENDING	☐ RECREATION	☐ TYING SHOES
☐ SITTING	☐ WORK	☐ DAILY ROUTINE
☐ TURNING HEAD	☐ DRIVING	☐ DESK WORK
☐ RISING FROM SEATED POSITION		☐ GETTING OUT OF BED
☐ PICKING ITEMS UP FROM THE FLOOR		

(DO NOT MARK BELOW THIS - OFFICE USE ONLY)

SYMPTOMS RECENTLY RETURNED OR INTENSIFIED? (_____) HX:				(RELIEVING)	(PROVOCATING)
				PRTX	IMAGE
CSB	CES	RAD/%	SLEEP	GLS	DX
+ORTH				TX	CONTRA

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PATIENT NAME: _____ DATE: _____

COMPREHENSIVE MEDICAL HISTORY: PLEASE CHECK IF YOU NOW, OR EVER, HAVE EXPERIENCED THE FOLLOWING:

CONSTITUTIONAL
1. ___ WEIGHT LOSS OR GAIN
2. ___ NIGHT SWEATS
3. ___ FEVER OR CHILLS
4. ___ CHANGE IN SLEEP
5. ___ OTHER

ENDOCRINE
6. ___ DIABETES
7. ___ THYROID DISEASE
8. ___ OTHER

EYE, EAR, NOSE, THROAT
9. ___ LOSS OF VISION
10. ___ PAIN IN EYE
11. ___ OTHER

PULMONARY
12. ___ ASTHMA
13. ___ COPD
14. ___ OTHER

GASTROINTESTINAL
15. ___ ULCER
16. ___ COLON POLYPS
17. ___ LOSS OF APPETITE
18. ___ GERD
19. ___ OTHER

CARDIOVASCULAR
20. ___ PACEMAKER/ICD
21. ___ SURGERY
22. ___ HIGH CHOLESTEROL
23. ___ HIGH BLOOD PRESSURE
24. ___ STROKE
25. ___ ANEURYSM
26. ___ OTHER

BLOOD LYMPH
27. ___ BLOOD CLOT
28. ___ BLEEDING DISORDER
29. ___ HIV/AIDS
30. ___ OTHER

MALE SPECIFIC (IF APPLICABLE)
31. ___ PROSTATE DISEASE
32. ___ OTHER

FEMALE SPECIFIC (IF APPLICABLE)
33. ___ BREAST LUMP OR PAIN
34. ___ OTHER

NEUROLOGIC/PSYCH
35. ___ NEUROPATHY
36. ___ SEIZURES
37. ___ SHINGLES
38. ___ DIZZINESS
39. ___ HEADACHES
40. ___ OTHER

GENITOURINARY
41. ___ URINARY TRACT INFECTION
42. ___ KIDNEY STONES
43. ___ INCONTINENCE
44. ___ OTHER

MUSCULOSKELETAL
45. ___ FREQUENT FRACTURES
46. ___ FIBROMYALGIA
47. ___ SCOLIOSIS
48. ___ ARTHRITIS
49. ___ GOUT
50. ___ OSTEOPOROSIS/OSTEOPENIA
51. ___ OTHER

SURGERIES
52. ___ YES (LIST DATES & SURGERY BELOW)
   A. _____
   B. _____
   C. _____
   D. _____

CANCER
53. ___ NONE
54. ___ YES (PLEASE LIST TYPE)
   A. _____
   B. _____

SOCIAL
55. ___ ALCOHOL
56. ___ CURRENT SMOKING/TOBACCO USE
57. ___ FORMER SMOKING/TOBACCO
58. ___ EXERCISE (TYPE AND FREQUENCY BELOW)
   A. _____

FAMILY HISTORY
1. ___ STROKE
2. ___ CANCER
3. ___ BLOOD CLOT
4. ___ ARTHRITIS
5. ___ OSTEOPOROSIS
6. ___ MUSCULOSKELETAL DISEASE
7. ___ HEART DISEASE
8. ___ HYPERTENSION
9. ___ NEUROPATHY
10. ___ OTHER
11. ___ NONE

PHYSICIAN COMMENTS:

BLOOD PRESSURE: _____MMHG
HEART RATE: _____BPM

MEDICATIONS: (PLEASE LIST BELOW):

MEDICATION NAME	CONDITION TREATING

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