wolke CHIROPRACTIC & REHABILITATION

Patient Application Form

Please Fill Out *Todays' Date:*

PATIENT INFORMATION:

Patient Name: Date Of Birth: Age: Male Female

Address: Apt#: SSN:

City: State: Zip Code: Home Phone:

Alternate Phone (Cell): Email Address:

Employer's Name: Occupation:

Work Address: City: State: Zip:

Work Phone: Ext: Date Symptoms Began:

Marital Status: Single Married Widowed

How did you hear about us?:

Emergency Contact: Phone:

IS YOUR CONDITION FROM AN AUTOMOBILE ACCIDENT? YES NO

INSURANCE INFORMATION:

Relationship to insured: Self Spouse Other Child Name of insured:

Insured's Employer: Same as above OR

Insured's SSN: Same as above OR

Insured's DOB: Same as above OR

Primary Insurance Company: Address:

City: State: Zip Code: Phone:

Policy Number: Group Number:

Secondary Insurance Company: Address:

City: State: ZipCode: Phone:

Policy Number: Group Number:

AUTHORIZATIONS:

A) I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B) I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C) I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Signature: Date:

Guardian Signature: Date:

Wolke Chiropractic & Rehabilitation
535 High Mountain Road
North Haledon, NJ 07508
T: (973) 423-9001 F: (973) 423-5525

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I here by request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am responsible) by the below named acupuncturist.

I understand that the methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, and electrical stimulation.

I have had the opportunity to discuss with the acupuncturist named below the nature and purpose of acupuncture treatments and other procedures.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases of dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, or tingling of the needle sites that last a few days. There have been rare instances reported of fainting, infection, and scarring. There have been extremely rare instances of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which is prescribed, based upon the facts then known, which are in my best interest.

I have read, or have had read to me, the above consent, I have also had the opportunity to ask questions about its content.

By signing below, I agree to the above named procedures, I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name: Date:

Signature:

Print Name:

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or is physically or legally incapacitated.

Patient Name:

Patient Representative:

Relationship of authority:

Witness:

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Patient Intake Form

Dear Patient,

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. The information you provide is confidential, Thank you for your cooperation.

Name: Date:

Address: Phone #:

Date of Birth: Age: Gender: ☐ M ☐ F Occupation:

Are you under the care of any other health care provider? ☐ Y ☐ N

If yes explain:

Please identify the health concerns that have brought you to seek treatment in order of importance below:

Condition:	**Date of Onset/Symptoms:**
1.	
2.	
3.	
4.	

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please indicate reaction):

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

Do you have any reason to believe you are pregnant? Y ☐ N ☐

If so, how far along are you?

Do you have any infectious diseases? ☐ Y ☐ N If yes, please identify:

Family History:

Please indicate any family health history such as, but not limited to cancer, diabetes, high blood pressure. ECT.

Height: Weight:

Blood pressure: What is your most recent blood pressure reading? When was it taken?

Please list any major illnesses (childhood & adult), surgeries, injuries and corresponding dates:

Emotional: (Please select any that you experience now or have experienced in the past):

☐ Difficulty Concentrating ☐ Mood Swings ☐ Nervousness ☐ Depression ☐ Panic Attacks ☐ Fear

Energy and Immunity: (please select any that you experience now or have experienced in the past:)

☐ Fatigue ☐ Slow wound healing ☐ Chronic Infections ☐ Chronic Fatigue Syndrome

Head, Eyes, Ears, Nose, and Throat: (please select any that you experience now or have experienced in the past):

☐ Impaired Vision ☐ Eye Pain ☐ Glaucoma ☐ Floaters ☐ Tearing/Dryness
☐ Impaired Hearing ☐ Ear Ringing ☐ Earaches ☐ Headaches ☐ Sinus Problems
☐ Nose Bleeds ☐ Dry Throat ☐ Frequent Sore Throat

Respiratory: (Please select any that you experience now or have experienced in the past):

☐ Pneumonia ☐ Frequent Common Colds ☐ Difficulty Breathing ☐ Emphysema
☐ Pleurisy ☐ Persistent Cough ☐ Asthma ☐ Tuberculosis
☐ Shortness of breath ☐ Other Respiratory Problems:

Cardiovascular: (Please select any that you experience now or have experienced in the past):

☐ Heart Disease ☐ Chest Pain ☐ Swelling of Ankles ☐ High Blood Pressure
☐ Palpations/ Fluttering ☐ Stroke ☐ Heart Murmurs ☐ Rheumatic Fever ☐ Varicose Veins

Gastrointestinal: (Please select any that you experience now or have experienced in the past):

☐ Ulcers ☐ Bloating ☐ Changes In Appetite ☐ Nausea/Vomiting ☐ Epigastric Pain
☐ Passing Gas ☐ Heartburn ☐ Belching ☐ Acid Reflux ☐ Hemorrhoids
☐ Abdominal Pain

Genito-Urinary Tract: (Please select any that you experience now or have experienced in the past):

☐ Painful Urination ☐ Frequent UTI ☐ Frequent Urination ☐ Incontinence
☐ Heavy Flow ☐ Impaired Urination ☐ Blood In Urine ☐ Frequent Urinations At Night

Female Reproductive/ Breasts: (Please select any that you experience now or have experienced in the past):

- ☐ Irregular Cycles
- ☐ Breast Lumps/Tenderness
- ☐ Nipple Discharge
- ☐ Heavy Flow
- ☐ Vaginal Discharge
- ☐ Premenstrual Syndrome
- ☐ Bleeding Between Cycles
- ☐ Clotting
- ☐ Menopausal Symptoms
- ☐ Difficulty Conceiving
- ☐ Painful Periods

Menstrual/Birthing History:

1. Age of First Menses:
2. # of Days of Menses:
3. Length of Cycle:
4. Birth Control Type:
5. # of Pregnancies:
6. # of Miscarriages:
7. # of Abortions:
8. # of Live Births:

Male Reproductive: (Please select any that you experience now or have experienced in the past):

- ☐ Sexual Difficulties
- ☐ Prostate Problems
- ☐ Testicular Pain/ Swelling
- ☐ Penile Discharge

Musculoskeletal: (Please select any that you experience now or have experienced in the past):

- ☐ Neck/ Shoulder Pain
- ☐ Muscle Spasm/ Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Joint Pain (if so, where?):

Neurological: (Please select any that you experience now or have experienced in the past):

- ☐ Vertigo/ Dizziness
- ☐ Paralysis
- ☐ Numbness/ Tingling
- ☐ Loss of Balance
- ☐ Seizures/ Epilepsy

Other: (Please select any that you experience now or have experienced in the past):

- ☐ Unusual Thirst
- ☐ Poor Memory
- ☐ Rashes
- ☐ Eczema/ Hives
- ☐ Cold Hands/ Feet

Is there anything else we should know about?

Lifestyle:

1. Do you typically eat at least three meals per day? ☐ Y ☐ N If no, how many?
2. How many glasses of water do you drink a day? Other Beverages?
3. Exercise routine:
4. Spiritual Practice:
5. How many hours per night do you sleep? Do you wake rested? ◯ Y ◯ N
6. Nicotine/ Alcohol/ Caffeine Use:
7. Have you experienced any major traumas? ☐ Y ☐ N
   Explain:
8. Interests and Hobbies:

What medications are you currently taking? abc def ghi

Name of Doctor's treating this condition? Current Prior

Phone Number:

Have you had chiropractic care before? ○ Y ○ N When/with whom:

Have you had one or more of the following?

☐ Aneurysm	☐ Osteoporosis	☐ Diabetes	☐ Arthritis	☐ Respiratory Conditions
☐ Epilepsy	☐ Cancer	☐ Strokes	☐ Allergies	☐ Heart Conditions
☐ Hepatitis	☐ Anxiety Attacks	☐ Fatigue	☐ Polio	☐ Sleeping Difficulty
☐ Pneumonia	☐ Pace Maker	☐ HIV	☐ Sinus Conditions	☐ Hypertension
☐ Thyroid Problems	☐ Depression	☐ Scoliosis	☐ Headaches	☐ Migraines
☐ Fainting	☐ Kidney Disease	☐ Parkinson's		

Other:

Female Only

1) Are you pregnant or by any chance you may be?

2) Date of the start of your last period:

3) Are you on any type of Birth Control?

Any Concerns?

Patient Signature: Date: