PENNINGTON FAMILY CHIROPRACTIC, P.C.

Confidential Patient Data

PATIENT INFORMATION Today's Date: _____

Name: _____ Date of Birth: _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

Please indicate which conditions have been experienced by the above by marking appropriate boxes.

S	M	F		S	M	F		S	M	F	
☐	☐	☐	anemia	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	arthritis	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	asthma	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	back pain	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	bladder trouble	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bone fracture	☐	☐	☐	hepatitis	☐	☐	☐	reproductive disorders
☐	☐	☐	bowel control loss	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatism
☐	☐	☐	cancer	☐	☐	☐	indigestion	☐	☐	☐	scoliosis
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	serious injury
☐	☐	☐	concussion	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition: _____ Date of Last Physical Exam: _____

ARE YOU PREGNANT? ☐ NO ☐ YES If yes, what week are you? _____

SURGICAL HISTORY

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

ACCIDENT HISTORY ☐ Job ☐ Auto ☐ Other 1. _____ Date _____

☐ Job ☐ Auto ☐ Other 2. _____ Date _____

FRACTURES _____

Are you currently taking any medications?	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Please continue on the reverse side if more space is required.

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

PLEASE CHECK ANY **SYMPTOMS** YOU MAY BE EXPERIENCING:

☐ blurred vision ☐ buzzing in ears ☐ cold feet ☐ cold hands ☐ cold sweats ☐ concentration loss/confusion ☐ constipation ☐ depression/weeping spells ☐ diarrhea ☐ dizziness ☐ face flushed ☐ fainting ☐ fatigue ☐ fever ☐ head seems too heavy ☐ headaches ☐ insomnia ☐ light bothers eyes ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ low resistance to colds ☐ muscle jerking ☐ numbness in fingers ☐ numbness in toes ☐ pins and needles in arms ☐ pins and needles in legs ☐ ringing in ears ☐ shortness of breath ☐ stiff neck ☐ stomach upset

Patient's Signature _____ Date _____

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General Function Index Questionnaire

We would like to know how much your condition ***presently*** prevents you from ***doing*** what you would normally do. Regarding each category, please indicate the ***overall*** impact your present condition has on your life, not just when the pain is at its worst. Please ***circle the number*** which best describes how your function is affected in these six categories of activities.

1. **Family/At-Home Responsibilities** such as yard work, chores around the house or driving the kids to school

0	1	2	3	4	5	6	7	8	9	10
completely able to function										totally unable to function

2. **Recreation** including hobbies, sports or other leisure activities

0	1	2	3	4	5	6	7	8	9	10
completely able to function										totally unable to function

3. **Social Activities** including parties, theater, concerts, dining out and attending other social functions with friends

0	1	2	3	4	5	6	7	8	9	10
completely able to function										totally unable to function

4. **Employment** including volunteer work and homemaking tasks

0	1	2	3	4	5	6	7	8	9	10
completely able to function										totally unable to function

5. **Self-Care** such as taking a shower, driving or getting dressed

0	1	2	3	4	5	6	7	8	9	10
completely able to function										totally unable to function

6. **Life-Support Activities** such as eating and sleeping

0	1	2	3	4	5	6	7	8	9	10
completely able to function										totally unable to function

Additional comments:

_____ _____

Patient Name Patient Signature

_____ _____ _____

Examiner Date Score [60]

Fuerstein M. Multidisciplinary rehabilitation of occupational musculoskeletal disorders. LACC Chiro Rehab. Chicago:Session 1, 9/95

PENNINGTON FAMILY CHIROPRACTIC, P.C.
2554 Pennington Road
Pennington, NJ 08534
609.737.3737

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided a copy of Pennington Family Chiropractic's Notice of Privacy Practices, which has an effective date of 9/22/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____	_____
Printed Name of Patient	Signature of Patient or Personal Representative
_____	_____
Date	Relationship to Patient (if not signed by the patient)

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance of the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. If we feel that we are unable to help you or that another provider would benefit you more, we will refer you to the appropriate provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____
PRINT NAME	**SIGNATURE**
_____	_____
DATE	**WITNESSED**