Welcome to The Chiro*Plus* Wellness Center

NEW PATIENT INFORMATION

Name _____ Today's Date _____

Street _____ City, State _____ Zip _____

Home Phone_____ Work Ph: _____ext:_____ Cell Ph: _____

E-mail: _____ Preference to contact: ❑Home ❑Work ❑Cell ❑E-mail ❑Any

Social Security #: _____-_____-_____ Birthday_____ Age: _____

Occupation _____ Employer _____

Referred by:_____ Marital Status: ❑S ❑M ❑D ❑W ❑Other. Spouse's Name: _____

Symptom 1*: _____ ⇨

Level of severity: Presently: 1 2 3 4 5 6 7 8 9 10
1: mild
10: severe
At best: 1 2 3 4 5 6 7 8 9 10
At worst: 1 2 3 4 5 6 7 8 9 10
On average: 1 2 3 4 5 6 7 8 9 10

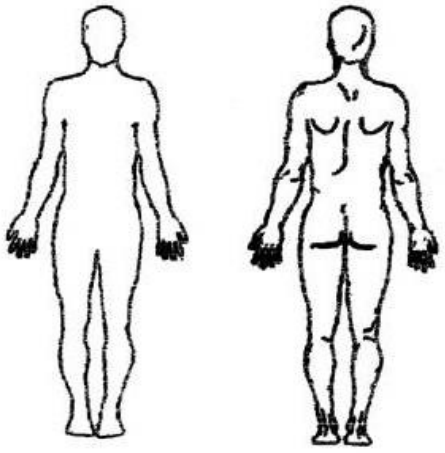
Symptom 2*: _____ ⇨

Level of severity: Presently: 1 2 3 4 5 6 7 8 9 10
At best: 1 2 3 4 5 6 7 8 9 10
At worst: 1 2 3 4 5 6 7 8 9 10
On average: 1 2 3 4 5 6 7 8 9 10

Symptom 3*: _____ ⇨

Level of severity: Presently: 1 2 3 4 5 6 7 8 9 10
At best: 1 2 3 4 5 6 7 8 9 10
At worst: 1 2 3 4 5 6 7 8 9 10
On average: 1 2 3 4 5 6 7 8 9 10

*Please indicate areas of symptoms on diagram below



Date of last Physical exam:_____ Family Dr:_____
Other Dr's seen for this problem: _____
Have you been treated for any other health condition in the past year? ❑ N ❑ Y, for:_____

Check the following you consume more than once per week: ❑Caffeine ❑Cereals ❑Alcohol ❑Diet foods ❑Smoking ❑Sweets ❑Bread ❑Salty foods ❑Dairy ❑Vitamins/Minerals ❑OTC Medications ❑Prescribed Meds

MEDICAL/ FAMILY HISTORY AND SYSTEMS REVIEW: **S = SELF M = MOTHER F = FATHER**

S	M	F		S	M	F		S	M	F	
❑	❑	❑	Allergy/ Sinus	❑	❑	❑	Endocrine/ Thyroid dysfunction	❑	❑	❑	Lumps, anywhere
❑	❑	❑	Liver, gall bladder problems	❑	❑	❑	Arthritis	❑	❑	❑	High Blood Pressure
❑	❑	❑	Lung/ Respiratory problem	❑	❑	❑	Stomach / digestive trouble	❑	❑	❑	Bone Disorder
❑	❑	❑	Menstrual pain	❑	❑	❑	Prostate problems	❑	❑	❑	Cancer
❑	❑	❑	Nagging cough / hoarse	❑	❑	❑	Unusual weight loss	❑	❑	❑	Diabetes
❑	❑	❑	Non-Healed Sores	❑	❑	❑	Reproductive disorders	❑	❑	❑	Skin, Hair, Nail problems
❑	❑	❑	Nervous system problems	❑	❑	❑	Difficulty Swallowing	❑	❑	❑	Chronic Fatigue
❑	❑	❑	Spinal Surgery	❑	❑	❑	Kidney/Bladder disorders	❑	❑	❑	Obvious Change in wart / mole

The information given above by me is accurate and complete: _____ Date: _____
(Signature)
In case of a minor, the signature of parent or guardian authorizing examination and treatment: _____
If accepted for care will you be using medical insurance? ❑ No ❑ Yes [Please provide insurance card(s), and sign below]

ASSIGNMENT AND CONSENT: I ASSIGN AND DIRECT MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECTLY TO THE CENTRAL JERSEY LORDEX SPINE INSTITUTE. I UNDERSTAND THAT IF MY INSURANCE COMPANY FAILS TO PAY FOR SERVICES RENDERED, I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCE ON MY ACCOUNT.

Print Name: _____ Date: _____

Signature: _____

Body Type Questionnaire

ChiroPlus Wellness Center

Name: _____ Date of Birth: _____ Today's Date: _____

Please Check the Items That Apply

Section 1 (T)

- ❑ Cravings for junk food, breads, or pasta
- ❑ Drinks wine in evenings
- ❑ Frustrating stubborn weight
- ❑ History of low-calorie diets
- ❑ History of up and down weight
- ❑ Fluid retention
- ❑ History of birth control pills
- ❑ History of Hormones Replacement Therapy
- ❑ High protein diets don't work
- ❑ Poor willpower
- ❑ Difficulty losing weight despite exercise
- ❑ History of blood sugar problems
- ❑ History of menstrual problems
- ❑ Often depressed
- ❑ Feel better on fruit and/or berries
- ❑ Brittle nails, with vertical ridges
- ❑ Weight problem evenly distributed on body
- ❑ Dry skin, especially on hands and elbows
- ❑ Loss or thinning of outer third of eyebrows
- ❑ Cold at night, prefer wearing socks to bed
- ❑ Puffiness around eyes
- ❑ Excessive shin sag under arms
- ❑ Dry hair and/or hair loss
- ❑ A "morning" person, excessively tired in early evening
- ❑ Lack of general vitality

Section 2 (female only) If you are post-menstrual, check those symptoms you had in the past. (O)

- ❑ PMS
- ❑ Irregular periods
- ❑ Depression during menstruation
- ❑ Bloating and cramping during menstruation
- ❑ Weight gain during menstruation
- ❑ Weight gain during ovulation
- ❑ Difficulty losing weight after pregnancy
- ❑ Heavy bleeding during menstruation
- ❑ Enlarged swollen breasts during menstruation
- ❑ Hot flashes
- ❑ Night Sweats
- ❑ Vaginal Dryness
- ❑ Leaky bladder
- ❑ Frequent urination at night
- ❑ Crave ice cream and/or milk
- ❑ Tendency toward constipation
- ❑ Pain in right or left lower back
- ❑ Upper body disproportionately thinner than lower body
- ❑ Menstrual cyclic "brain fog"
- ❑ Low sex drive
- ❑ Pre-menstrual water retention
- ❑ History of ovarian or breast cysts

Section 3 (A)

- ❑ Out of breath when walking up stairs
- ❑ Difficulty getting up from seated position
- ❑ Dizziness when getting up too quickly
- ❑ Chronic inflammation in body
- ❑ Occasional twitching of left eyelid
- ❑ Perspiring after getting out of shower
- ❑ Fatigue during the day
- ❑ "Night person"; difficulty getting out of bed in morning
- ❑ Waking up in the middle of the night
- ❑ Difficulty falling to sleep
- ❑ Afternoon headaches
- ❑ Arthritis or stiff and painful joints
- ❑ Bursitis, Tendonitis
- ❑ Cramps in calves at night
- ❑ Low tolerance for stress
- ❑ Heel spurs
- ❑ Crave salt or chocolate
- ❑ Tendency to worry, nervous, anxious
- ❑ (Female): facial hair
- ❑ Swollen ankles - socks leave creases

Section 4 (L)

- ❑ Low back weakness or pain
- ❑ Nervousness
- ❑ Fluid retention
- ❑ Tight feeling in lower right abdomen
- ❑ Frequent pain or tightness in right shoulder
- ❑ Tendency for dandruff
- ❑ Dark yellow urine
- ❑ Feet often feel hot
- ❑ Morning headaches
- ❑ Skin problems; brown spots, psoriasis, eczema
- ❑ Itching, especially at night
- ❑ Yellow tint in the whites of eyes
- ❑ Moodiness if meal is skipped
- ❑ Dehydrated despite amount of fluid consumed
- ❑ Swollen ankles
- ❑ Craving potato chips or deep fried foods
- ❑ Irritable or grouchy in morning
- ❑ Enlarged bump in upper back/lower neck
- ❑ Hands and feet go to sleep easily
- ❑ Dull chest pain
- ❑ Muscle cramps, worse during exercise

Section 5 (Adv L)

- ❑ Gall bladder was removed
- ❑ History of gallstones
- ❑ Could not lose weight on high protein diets (e.g. Atkins)
- ❑ Difficulty digesting heavy protein-type foods
- ❑ "Gassy" after fatty or greasy foods
- ❑ History of Liver problems
- ❑ Protruding, distended belly; "potbelly"

Acknowledgement of Receipt of Notice of Privacy Practices

From the Offices of Richard Therkelsen, D.C.
400 Belchase Dr., Suite 404 / Matawan, NJ 07747

I understand that I have the right to refuse to sign this acknowledgement.

I, _____, have received a copy of the Notice of Privacy Practices for the above referenced practice.

_____
(PLEASE PRINT NAME)

_____ _____
(SIGNATURE) (DATE)