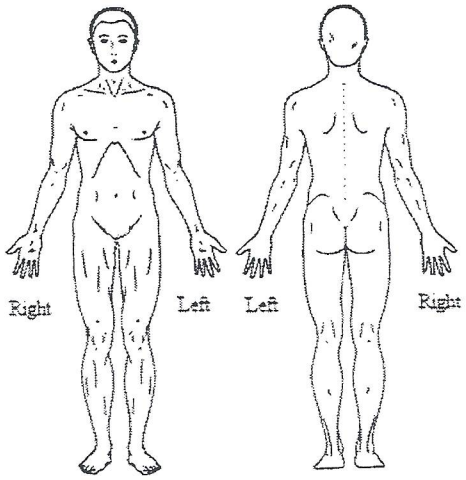
cell phone #

CASE HISTORY

Name _____ Age _____ Date _____
Address _____ City _____ State_____ Zip_____
Phone (Home) _____ Date of Birth _____ Sex: M F Marital Status: S M D W
Social Security # _____ Driver's License # _____
Occupation Employer _____ Phone (Work)_____
Insurance Company_____ Phone_____
Insured's Name _____ Insured's Date of Birth _____
Insured's ID. # or S.S. # _____
Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer _____ Spouse's Phone (Work)_____
Spouse's Insurance Co. _____ Phone_____
Spouse's Social Security # _____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other _____
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other _____

HEALTH REPORT:

Reason for seeking care: _____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____
List the names of any relatives that have or have had a similar problem: _____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Are you currently taking medication? __ Yes __ No list medications: _____
_____
Have you taken medication in the past? __ Yes __ No list medications _____
List conditions you are taking medications for: _____
List the approximate dates of any surgery or treated conditions:_____
_____
Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____
Do you smoke Y/N ____ •Alcohol Y/N __Daily __Weekly __Social Occasions •Caffeinated drinks per day ____
Do you take Vitamins/Supplements Y/N If yes, type and how often _____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10
Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

What activities aggravate your condition/pain?_____
What activities lessen your condition/pain?_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?_____
Sleep?_____Routine?_____Other?_____
Is this condition progressively getting worse?_____
_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.
Patient
Signature_____ Date_____

ASSIGNMENT OF BENEFITS FORM

A&A Chiropractic
52 Tennent Rd. Morganville, NJ 07751
Phone #: 732-591-9200 / Fax #: 732-591-2332
Email: Slinkdc@optonline.net

Patient Name:_____

I irrevocably assign to A&A Chiropractic all my rights and benefits under any insurance contracts for payment for services rendered to me by A&A Chiropractic. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by A&A Chiropractic to be released to A&A Chiropractic to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to A&A Chiropractic, to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature: _____

A & A Chiropractic

Dr. Sharon Barnum

52 Tennent Rd Morganville, NJ 07751

Phone#: 732-591-9200/Fax 732-591-2332

Email: - Slinkdc@optonline.net

INSURANCE INFORMATION

Name of Insured: _____

Relationship to Patient: _____

Date of Birth: _____

Social Security Number: _____

Insurance Company: _____

I.D. Number: _____

Policy Number: _____

Are you the primary holder? _____

If not the primary holder, give name of primary and date of birth: _____

_____

Additional Insurance: _____

Name of Employer: _____

Address of Employer: _____

Telephone Number of Employer: _____

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____	_____
Patient Name (printed)	Relationship to patient
_____	_____
Patient or legal Guardian Signature	Date
_____	_____
Witness Signature (office staff)	Date

A & A Chiropractic
Dr. Sharon Barnum
52 Tennent Rd. Morganville, NJ 07751
Phone: 732-591-9200 / Fax #: 732-591-2332
Email: - Slinkdc@optonline.net

I HAVE READ THE POSTED NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THE POLICY AND MY RIGHTS.

Dated: _____

_____ _____

Patient's Name Patient's Signature

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- ☐ All employment, personnel or wage records.
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____ .

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human

immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(vi)) Date

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR § 164.508(c)(1)(iv))

Witness Signature Date