Dr. Christopher J. Bott
Causeway Chiropractic

145 East Bay Avenue
Manahawkin, New Jersey 08050
609-361-1800
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NAME _____ DATE _____
AGE _____ MARITAL STATUS: M S D W # OF CHILDREN _____
OCCUPATION _____
PHYSICAL ACTIVITIES / HOBBIES _____

PRIMARY CARE PRACTITIONER _____
LAST PHYSICAL EXAM _____ LAST BLOOD WORK _____
LAST EYE EXAM _____ LAST DENTAL EXAM _____
HEIGHT _____ WEIGHT _____ R / L HANDED _____
HAS WEIGHT CHANGED IN THE PAST (3) MONTHS? HOW MUCH? _____

LAST MENSTRUAL PERIOD _____ ANY CHANGES W/ CYCLE? _____
LAST GYN EXAM _____ LAST PAP SMEAR _____
LAST MAMMOGRAM _____ LAST BONE DENSITY _____
OF PREGNANCIES _____ TYPE(S) OF DELIVERY _____
IS THERE ANY CHANCE OF PREGNANCY AT THIS TIME? _____

TOBACCO USE (PACKS / DAY) _____ CAFFEINE USE (CUPS / DAY) _____
ALCOHOL USE (DRINKS / WEEK) _____ OTHER TOXIN EXPOSURE _____

MEDICAL HISTORY

Have you or a family member experienced any of the following conditions?

S = SELF F = FAMILY MEMBER

___ HEART CONDITION
___ CANCER
TYPE/TREATMENT: _____
___ HIGH BLOOD PRESSURE
___ DIABETES
___ STROKE/ANEURYSM/CIRCULATORY
___ THYROID DISORDER
___ ASTHMA/EMPHYZEMA/PULMONARY
___ DIGESTIVE DISORDER
___ SEIZURE
___ HEADACHE
___ DIZZINESS/VERTIGO
___ NUMBNESS/TINGLING
___ HEARING LOSS/ RINGING IN EARS
___ CHANGE IN VISION
___ LYME DISEASE
___ ARTHRITIS
___ OSTEOPENIA/OSTEOPOROSIS
___ JOINT PAIN
___ NECK/BACK PAIN
___ ARM PAIN/WEAKNESS
___ LEG PAIN/WEAKNESS
___ ALLERGIES/HAYFEVER
___ CHRONIC FATIGUE
___ FIBROMYALGIA
___ DEPRESSION/ANXIETY
___ SUBSTANCE ABUSE

HAVE YOU EVER BEEN INVOLVED IN A MOTOR VEHICLE ACCIDENT?
(DATE & INJURIES): _____

DO YOU HAVE A HISTORY OF PHYSICAL TRAUMA? (SPORTS, SLIP/FALL…)

PLEASE DESCRIBE ANY SURGICAL HISTORY/MEDICAL PROCEDURES: _____

PLEASE EXPLAIN YOUR CURRENT MEDICAL TREATMENT(S)/ROUTINE MONITORING:

PLEASE PROVIDE YOUR CURRENT MEDICATIONS (OVER THE COUNTER AND PRESCRIPTIONS):

PLEASE PROVIDE ANY CURRENT SUPPLEMENTS/DIETS: _____

PLEASE DESCRIBE ANY COMPLIMENTARY/ALTERNATIVE HEALTHCARE PRACTICES/REGIMENS:

ADDITIONAL COMMENTS:

CURRENT HISTORY

WHAT ARE YOUR PRESENT SYMPTOMS/PURPOSE OF THIS CONSULTATION? _____

_____

_____

WHEN DID YOUR SYMPTOM(S) START?: _____

HOW DID YOUR INJURY OCCUR? _____

_____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOM(S)?:

A. CONSTANTLY (76-100% OF THE DAY)
B. FREQUENTLY (51-75% OF THE DAY)
C. OCCASIONALLY (26-50% OF THE DAY)
D. INTERMITTENLY (0-25% OF THE DAY)

DESCRIBE THE NATURE OF YOUR SYMPTOMS:

A. SHARP B. DULL ACHE C. NUMB
D. SHOOTING E. BURNING F. TINGLING

WHAT TREATMENT HAVE YOU RECEIVED (INCLUDING HOME CARE)? _____

_____

HAS YOUR PAIN INCREASED, DECREASED OR STAYED THE SAME? _____

HOW HAS YOUR SLEEP QUALITY BEEN AFFECTED BY YOUR SYMPTOM(S)? _____

_____

DOES YOUR PAIN INCREASE WITH COUGHING, SNEEZING, BOWEL MOVEMENT? _____

HOW DOES STANDING, SITTING, OR LYING AFFECT YOUR PAIN? _____

HOW DOES TIME OF DAY AFFECT YOUR SYMPTOM(S)? (AM VS. PM) _____

_____

HOW HAVE YOUR DAILY ACTIVITIES CHANGED? _____

_____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? Y / N

IF SO, WITH WHOM DID YOU TREAT?:

A. ANOTHER CHIROPRACTOR B. MEDICAL PRACTIONER

C. PHYSICAL THERAPIST D. OTHER _____

WHAT DO YOU THINK IS CAUSING YOUR CONDITION? WHAT ARE YOUR CONCERNS?

_____

_____

WHAT ARE YOUR EXPECTATIONS/GOALS OF TREATMENT:(SHORT & LONG TERM)?

_____

_____

PREVIOUS CHIROPRACTIC EXPERIENCE

LAST ADJUSTMENT/TREATMENT: _____

TYPE OF ADJUSTMENT/TREATMENT: _____

PREVIOUS DOCTOR'S NAME/LOCATION: _____

REASON FOR DISCONTINUING PREVIOUS CARE: (OPTIONAL) _____

_____

COMMENTS: _____

_____

_____

PATIENT'S SIGNATURE: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____

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Consent for the Purposes of Treatment, Payment and Other Health Care Options

I, _____ give consent to Causeway Chiropractic and Dr. Christopher J. Bott to use and disclose my Individual Health Information or Protected Health Information for these specific purposes:

1. Providing treatment to me.
2. Relating to the payment of the services this office has rendered me.
3. The general administrative operations this practice provides me.

I understand that I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment, payment and healthcare operation of Causeway Chiropractic but Causeway Chiropractic, is not required to agree to these restrictions. However, if Causeway Chiropractic agrees to such a request, the restriction is binding upon the practice.

Written and Verbal Communications
Please read the following and **answer** appropriately.
Can this office send newsletters or other written information to your home? **YES/ NO**
Can this office leave a message at your home? **YES/ NO**
Can this office leave a message at your office? **YES/ NO**

Please read the following and **initial** in the space provided.

_____ I understand I have the right to read and discuss the Notice of Privacy Policies and Procedures form of this chiropractic office before I sign this consent form regarding the use and disclosure of my Protected Health Information.

_____ I have the right to revoke this consent, in writing, at any time, exempting the chiropractor and practice to the extent that they have already relied upon this consent.

_____ I have read, reviewed, understand, and agree to the statement of the Privacy Policy for healthcare services in this office. Causeway Chiropractic, has attempted to provide each patient with a statement of Privacy Policies.

I hereby authorize Causeway Chiropractic and Dr. Christopher J. Bott to disclose my protected health information to the following individual.

Name: _____ **Relationship:** _____

Telephone number _____

_____

Signature of Patient or Personal Representative (relationship to patient) Date

_____

Print Name

INSURANCE INFORMATION

PATIENT'S NAME: _____
PHONE: (HOME) _____ **(WORK)** _____ **(CELL)**_____
ADDRESS: _____
PATIENT'S DATE OF BIRTH: ___/___/___ **E-MAIL** _____

INSURED'S NAME (IF DIFFERENT FROM PATIENT): _____
ADDRESS: _____
INSURED'S DATE OF BIRTH: ___/___/___

INSURANCE COMPANY _____
ID# _____ GROUP# _____

DO YOU HAVE **SECONDARY COVERAGE**? IF SO, PLEASE PROVIDE:

INSURED'S NAME: _____
INSURED'S DATE OF BIRTH: ___/___/___

INSURANCE COMPANY _____
ID# _____ GROUP# _____

I UNDERSTAND AND AGREE THAT THE HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE COMPANY AND MYSELF. FURTHERMORE, I UNDERSTAND THAT CAUSEWAY CHIROPRACTIC WILL PREPARE ANY NECESSARY FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT THE AMOUINT AUTHORIZED TO BE PAID DIRECTLY TO CAUSEWAY CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

AUTHORIZATION TO PAY PHYSICIAN:
I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY PROCEEDS OF ANY BENEFITS DUE TO ME BY CHECK AND MAIL TO:

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IF IT IS THE CASE THAT I HAVE NO INSURANCE COVERAGE FOR CHIROPRACTIC CARE, THEN I MYSELF WILL BE RESPONSIBLE FOR AND ALL CHARGES.

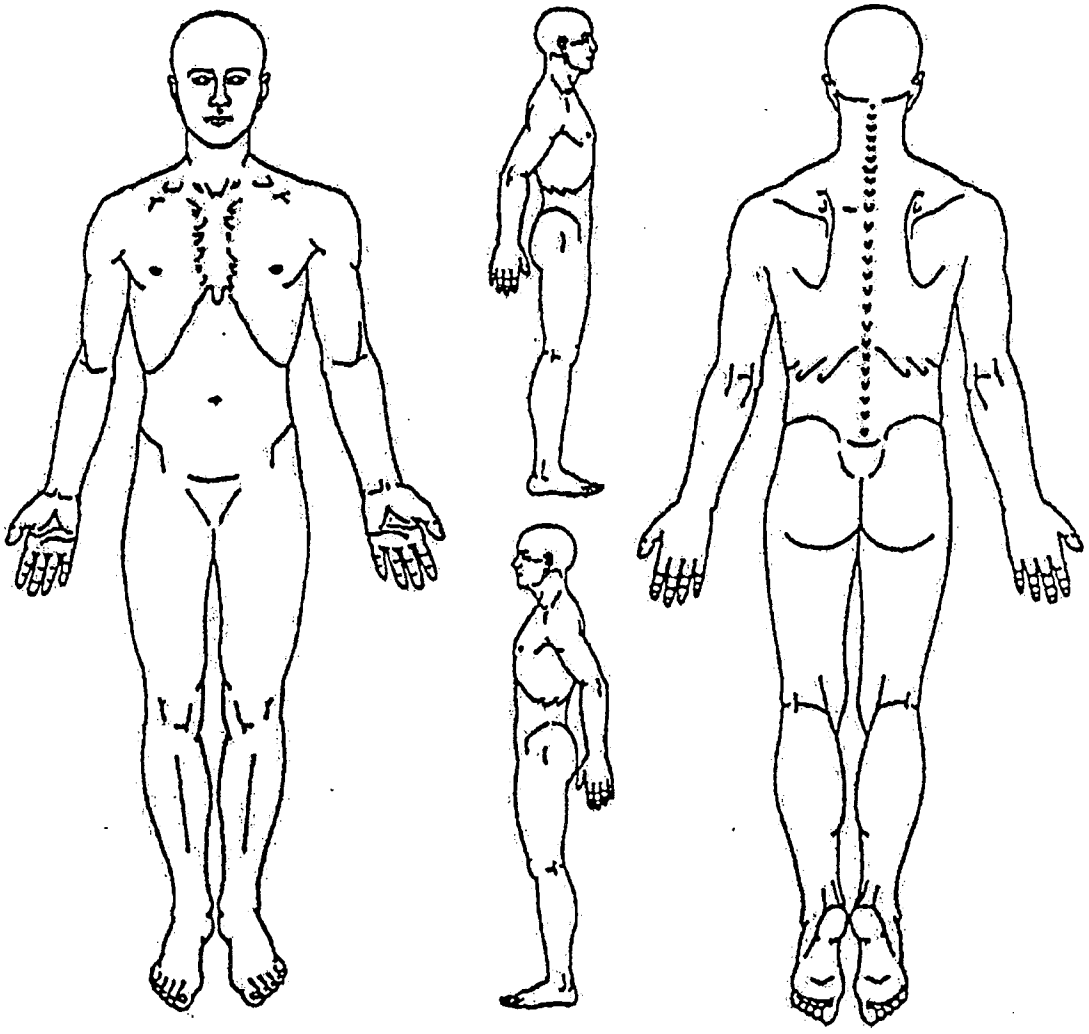
ALL PATIENTS PLEASE SIGN BELOW:

PATIENTS'S SIGNATURE
_____ DATE _____
INSURED'S OR GUARDIAN'S
SIGNATURE _____DATE_____

PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A = Ache	B = Burning	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

NAME: (please print)_____

How long have you experienced neck/back pain? _____ Years _____ Months _____ Weeks

Is this your first episode of neck/back pain? _____ YES _____ NO

SIGNATURE:_____ DATE:_____

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