Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ City _____

State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing ☐ Y ☐ N

Medical Conditions

Check (✓) yes or no whether you have had or currently have any of the following medical conditions?

☐ Y ☐ N Heart Attack/Stroke
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Fainting/ Seizures/Epilepsy
☐ Y ☐ N Shingles
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Difficulty Breathing
☐ Y ☐ N Hepatitis
☐ Y ☐ N Anemia

☐ Y ☐ N Arthritis
☐ Y ☐ N Frequent Neck Pain
☐ Y ☐ N Jaw Pain
☐ Y ☐ N Wrist Pain
☐ Y ☐ N Shoulder Pain
☐ Y ☐ N Arm Pain
☐ Y ☐ N Leg Pain
☐ Y ☐ N Lower Back Problems
☐ Y ☐ N Severe/ Frequent Earaches

☐ Y ☐ N Ringing in Ears
☐ Y ☐ N Severe/ Frequent Headaches
☐ Y ☐ N Diabetes/Tuberculosis
☐ Y ☐ N Dizziness
☐ Y ☐ N Emphysema/Glaucoma
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Artificial Bones/Joints
☐ Y ☐ N Cancer
☐ Y ☐ N HIV Positive/AIDS

☐ Y ☐ N Ulcer/Colitis
☐ Y ☐ N Gout
☐ Y ☐ N Numbness, where? _____
☐ Y ☐ N Tingling, where? _____
☐ Y ☐ N Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Shari L. Saluck, D.C.
212 Haddon Avenue
Haddonfield, NJ 08033

REVIEW OF SYSTEMS

Patient's Name_____ Date_____
Treating Physician_____ DOB_____

Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please identify if this is a problem that you currently have.)

		Yes	No	Current	Explain
Constitution:	Sudden weight loss or gain?	___	___	___	_____
Eyes:	Changes in vision?	___	___	___	_____
	Watering, itching, burning?	___	___	___	_____
	Pain or pressure?	___	___	___	_____
Ears,	Changes in hearing?	___	___	___	_____
Nose,	Bleeding or discharge?	___	___	___	_____
Mouth,	Blisters in mouth?	___	___	___	_____
Throat:	Throat pain?	___	___	___	_____
Cardio-	Chest pain?	___	___	___	_____
vascular:	Palpitations?	___	___	___	_____
	Ankle swelling?	___	___	___	_____
Respiratory:	Difficulty breathing?	___	___	___	_____
	Coughing?	___	___	___	_____
Gastro-	Abdominal pain?	___	___	___	_____
intestinal:	Blood in stool?	___	___	___	_____
	Any color changes in stool?	___	___	___	_____
Genito-	Frequent urination?	___	___	___	_____
urinary:	Blood in urine?	___	___	___	_____
	Painful urination?	___	___	___	_____
Musculo-	Joint pain?	___	___	___	_____
skeletal:	Muscle pain?	___	___	___	_____
Neurologic:	Headaches?	___	___	___	_____
	Numbness, Tingling?	___	___	___	_____
Hematologic/	Swollen glands?	___	___	___	_____
Lymphatic:	Bleeding problems?	___	___	___	_____
Endocrine:	Increase thirst?	___	___	___	_____
	Changes in temperature?	___	___	___	_____
Skin:	Rashes?	___	___	___	_____
	Itching?	___	___	___	_____
Allergic/	Allergies?	___	___	___	_____
Immunologic:	Immune disorders?	___	___	___	_____