SANDOZ CHIROPRACTIC

Sandoz Chiropractic Center
2057 Briggs Road Suite 204
Mount Laurel, NJ 08054
PH: 856-206-9560 Fax: 856-206-9701
www.sandozchiropractic.com
frontdesk@sandozchiropractic.com

Welcome To Sandoz Chiropractic Center
CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden Name: _____

Race (choose one): [Asian] [African American] [Caucasian] [Hispanic] [Native American] [Other]

Ethnicity (choose one): [Non-Hispanic] [Hispanic] [Withheld]

Address: _____ Postal Code: _____

City _____ State: _____ E-mail address: _____

Appointment reminder preference: [Cell Phone Call] [Home Phone Call] [Text Message] [E-mail]

(Circle more than one above if you would prefer that)

Home Phone _____ Work Phone _____ Cell Phone _____

Cell phone carrier (for text messages) [AT&T] [Verizon] [Sprint] [Virgin] Other _____

Date of Birth / / Social Security Number - -

Gender: [Male] [Female] Height: ft in Weight: lbs.

Married Single Divorced Widow(er) Number of Children Pregnant: Due Date:

Employer _____ Occupation _____

Emergency Contact: _____ Contact Phone # _____

Whom may we thank for referring you? _____

Primary Care Doctor: _____ Phone: _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____

List all accidents or injuries:

Type _____ When _____ Hospitalized? _____

List all surgeries:

Type _____ When _____

List medications and/or vitamins and supplements you are taking

Name _____ For _____ How long _____

Name _____ For _____ How long _____

Use back of sheet for any additional space needed.

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the area of radiating pain, and include all affected areas. You may draw on the face as well.

Pain Symbols:

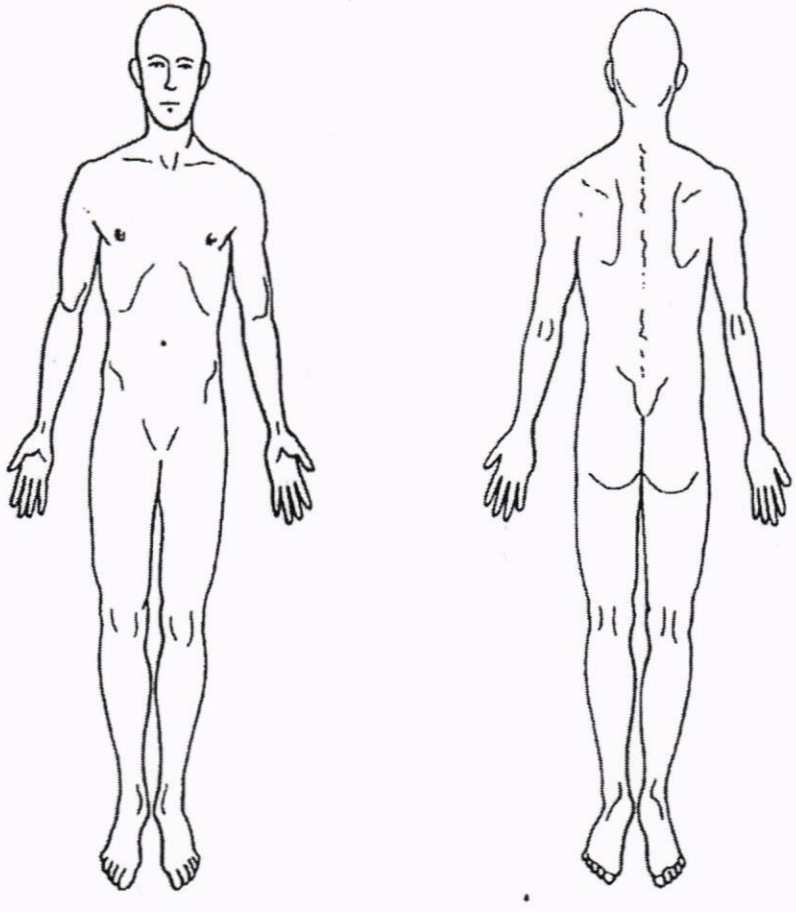
Numbness

Pins & Needles
ooooooo

Burning Pain
xxxxxxxx

Stabbing Pain
//////////

Aching Pain
(((((((((



Chief Complaint: _____

Patient Explanation of Incident: _____

Date of Onset: _____ Did symptoms appear gradually or suddenly? _____

On the Job: Yes No Days off work: _____

Auto Accident: Yes No Days off work: _____

Sandoz Chiropractic Center - Phone: 856-206-9560 Fax: 856-206-9701
frontdesk@sandozchiropractic.com www.sandozchiropractic.com

Patient Name: _____ Date: _____

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	**Musculoskeletal**	Present
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Pain in upper leg or hip	[ ]
[ ]	Pain in lower leg or knee	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints)	[ ]
	_____	
[ ]	Stiffness of joints (list joints)	[ ]
	_____	

Past	**Nervous System**	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bed wetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	**Cardiovascular**	Present
[ ]	Rapid heartbeat	[ ]
[ ]	Chest pains	[ ]

Past	**Endocrine**	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	Respiratory	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Chronic sinusitis	[ ]

Past	**Gynecologic**	Present
[ ]	Pain during menstruation	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	**Genito-Urinary**	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	**GI Tract**	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	**Skin**	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

[ ]	Tobacco
[ ]	Alcohol, Qty/Frequency
[ ]	Tranquilizers/Sedatives
[ ]	Laxatives
[ ]	Coffee, cups/day
[ ]	Regular soda, cans/day
[ ]	Diet soda, cans/day
[ ]	Water

Family History: Listed below are common diseases and disorders. Please indicate whether you have a Parent, Sibling, and or Grandparent who have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	**Condition**	Present
[ ]		[ ]
[ ]	Heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]
[ ]		[ ]

Past	**Condition**	Present
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]		[ ]
[ ]	Other	[ ]
[ ]	Other	[ ]
[ ]	Other	[ ]

Sandoz Chiropractic Center - Phone: 856-206-9560 Fax: 856-206-9701
frontdesk@sandozchiropractic.com www.sandozchiropractic.com

SANDOZ CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION, DIAGNOSTIC X-RAYS AND TREATMENT, AUTHORIZATION AND RELEASE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction, spinal decompression) and diagnostic x-rays, on myself (or on the patient named below for whim I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the Sandoz Chiropractic Center or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, stokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to the Sandoz Chiropractic Center. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the Sandoz Chiropractic Center to communicate with my medical physician(s) about my conditions and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also agree that if my account goes into a 'collection state' for non-payment a charge of 35% will be incurred on the total amount owed. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for future conditions(s) for which I seek treatment.

Patient's Signature: _____ Date: _____

Printed Name: _____

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize the doctors of Sandoz Chiropractic Center, and/or whomever they may designate as assistants to administer treatment as deemed necessary to _____.

Signature of Parent or legal guardian: _____ Relationship: _____

Date: _____ Witness Signature: _____

X-RAY PREGNANCY RELEASE FORM

To the best of my knowledge, I am NOT pregnant and I consent to protected Radiograph exposure at Sandoz Chiropractic Center.

I am or may be pregnant, however, I consent to limited protected Diagnostic Radiographs of my Cervical Spine (Neck).

Patient's Signature: _____ Date: _____

Sandoz Chiropractic Center - Phone: 856-206-9560 Fax: 856-206-9701
frontdesk@sandozchiropractic.com www.sandozchiropractic.com