Pollack Health and Wellness

Patient Intake

Patient Name:		Social Security #:	
Gender:	Date of Birth:	Age:	
Mailing Address:	City:	State:	Zip Code:
Email Address:			
Home Phone #:	Cell #:	Work Phone #:	
Employer:			
Occupation:			
Number of Biological Children:		Marital Status: S / M / D / W	

Insurance Information

Primary Insurance Company Name:		Type (Circle One): MEDICAL / AUTO / OTHER	
Company Address:			
ID#:	Group#:	Claim#:	Subscriber SSN#:
Subscriber Name:	Subscriber D.O.B:	Relation to Subscriber (if applicable):	
Coverage Effective Date:		Date of Injury:	

Secondary Insurance Information

Primary Insurance Company Name:		Type (Circle One): MEDICAL / AUTO / OTHER	
Company Address:			
ID#:	Group#:	Claim#:	Subscriber SSN#:
Subscriber Name:	Subscriber D.O.B:	Relation to Subscriber (if applicable):	Coverage Effective Date:

IN CASE OF EMERGENCY NOTIFY (Name & Phone #):
How were you referred to our office? Family/Friend_____ Internet _____ Physician_____ Newspaper/Magazine _____Sign_____ Other _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Previous or referring doctor:	

Reason for Today's Visit:

How long have you had this problem? (days/ weeks / months, etc.):

What makes it better or worse? (Please include any prior treatments, i.e medications, physical therapy, injections, etc.):

Rate the Pain (0= no pain, 10 = worst imaginable pain):

PERSONAL HEALTH HISTORY		
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other (Please specify below)		
Immunizations and dates (If unknown, leave blank):	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries (If none, leave blank):

Year	Reason	Hospital

Other hospitalizations (If none, leave blank):

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No

Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Did you know? **People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in the body. Your doctor will weigh your needs and desires when recommending your care program.**

Were you aware that…

Doctors of Chiropractic work with the nervous system?	☐ Yes	☐ No
The nervous system controls all bodily functions and systems?	☐ Yes	☐ No
Chiropractic is the largest natural healing profession in the world?	☐ Yes	☐ No

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Pollack Health and Wellness, Inc. to use and disclose your protected heath care operations. Our Notice of Privacy Practice provides more detailed information about how we may use and disclose protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 732-244-0222. You have the right to request that we restrict how we use and disclose you protected health information for the purpose of treatment, payment or heath care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed you protected health information in reliance on your consent.

_____ _____

Signature Date

Pollack Health and Wellness

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending Physician(s) and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the Physician(s) accepting the assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Signature: _____

VERIFICATION OF NON-PREGNANCY:
Date of LMP _____
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is the pregnancy suspected or confirmed at this particular time.
Signature: _____

Other than patient, print name and relationship:
Witness: _____ **Date:** _____

Patient Name: _____ **Date:**_____

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FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

To provide timely and accurate payment to **Pollack Health and Wellness** for any services furnished, the patient above certifies:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to Pollack Health and Wellness and its providers.
- I request that payment of authorized benefits be made on my behalf to Pollack Health and Wellness for any services furnished to the above patient.
- If my Health Insurance Plan will not direct payment to Pollack Health and Wellness, I agree to forward to Pollack Health and Wellness all health insurance payments which I receive for the services rendered by this office and its providers.
- I authorize Pollack Health and Wellness or any holder of medical information about me, or the patient listed above, to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan, unless other arrangements have been made through Pollack Health and Wellness.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Pollack Health and Wellness.

I certify that I have read and understand the above statements:

_____

Patient/ Responsible Party

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Informed Consent to Chiropractic and Physical Therapy Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required to obtain informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/ adjustments involving movement of the joints and soft tissues. Physical therapy, traction, ultrasound, hot packs, TENS unit, exercises, and other therapeutic modalities may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that, like exercises, it is common to experience muscle soreness in the first few treatments.

Fractures/Joint injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes with chiropractic adjustments are rare. I am aware that nerve damage or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of complications from treatment, and I freely assume these risks.

Treatment Results

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, and possible surgery.

Consent to evaluate and treatment of a minor child: (if applicable)

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my cild to receive chiropractic care and/or physical therapy.

I have read or have had read the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____

Date Patient Signature

_____ _____

Date Witness