



Welcome

TO NELSON CHIROPRACTIC CENTER

Have you ever consulted a chiropractic physician before? Yes No

Date: _____

Name: _____

Address: _____

City, Zip: _____

Phone # : _____

Gender: M F

Age _____ Birth Date: _____

Single Married Separated Divorced

Occupation _____

Employer _____

Referred By _____

E-mail Address _____

Emergency Contact _____

Telephone # _____

Do you have a family physician? Yes No

Dr.'s Name: _____

Would you like a report sent to this doctor? Yes No

Would you like a report sent to any other health care provider? Yes No

If so, Please list name and address:

2020

Insurance Coverage

Welcome to **Nelson Chiropractic Center**. Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our office will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

Copays

All copays and coinsurance MUST be paid at the time of service. Copay and Coinsurance WILL be collected BEFORE you are seen in our office. Please be prepared to pay your portion of your balance.

Missed Appointments

It is the policy of **Nelson Chiropractic Center** to assess a **\$25** missed visit fee to patients who cancel appointments with less than a 24-hour notice. This office also reserves the right to reschedule your appointment if you are more than 10 minutes late. This office provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

Consent for Treatment

I, the undersigned, hereby authorize all the doctors and whomever she/he may designate as his/her assistant(s) at Nelson Chiropractic Center to perform diagnostic tests and to administer treatment as necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt the conveyance of credit to my account.

Consent for Treatment of a Minor

I authorize Nelson Chiropractic Center to administer chiropractic care, as deemed medically necessary, to my child.

Patient Signature: _____ Date: _____

289 WHITE HORSE PIKE, SUITE 201 - ATCO, NJ 08004

CERTIFIED CHIROPRACTIC SPORTS PHYSICIANS

CERTIFIED CHIROPRACTIC REHABILITATION DOCTOR

POLESTAR PILATES REHABILITATION CERTIFIED

2020

RECORDS RELEASE SIGNATURE

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's Signature _____ Date ____/____/____

X-Ray/Medical Records Release

I have requested the release of records of which are a part of records at:

I hereby request and authorize you, your employees and agents to furnish all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning treatment that I may have had in the past, now have, or may have in the future to Nelson Chiropractic Center.

Patient's Signature _____ Date ____/____/____

Email: _____

289 WHITE HORSE PIKE, SUITE 201 - ATCO, NJ 08004

CERTIFIED CHIROPRACTIC SPORTS PHYSICIANS

CERTIFIED CHIROPRACTIC REHABILITATION DOCTOR

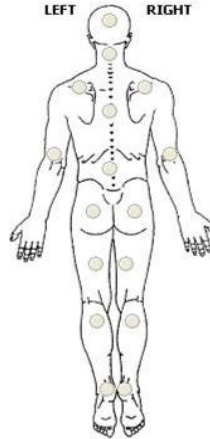
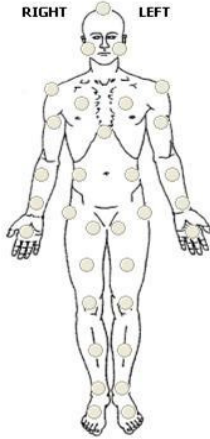
POLESTAR PILATES REHABILITATION CERTIFIED

COMPLAINT
 (Initial Exam, Daily Note, Follow Up/Final Exam)

Complaint # ___ -

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) 0 1 2 3 4 5 6 7 8 9 10



Other: _____

This complaint came on:

It is getting:

The intensity of this complaint is:

The frequency of this complaint is: Intermittent

The pain is:

The pain is located on:

Actions effecting this complaint:

Morning

Afternoon

Cold

Heat

Medication

Resting

Straining

Standing

Sitting

Lying down

Bending forward

Bending back

Bending left

Twisting left

Twisting right

Lifting

Coughing

Sneezing

Gradually

Improving

Minimal Slight

Occasional

Dull

Shooting

Burning

Left side

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Brings On

Immediately

Staying the same

Moderate

Frequent

Sharp

Spasm

Spasm

Right side

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Aggravates

Getting Worse

Severe

Constant

Aching

Throbbing

Tingling

Both sides

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

Relieves

LAST NAME: _____ FIRST NAME: _____ MI: _____ Date: _____

What brings you into our office? **Not accident related**

Do you feel your condition is: Improving Staying the same Getting worse

Have you lost time from work? Yes No

Can you perform physical work activities? Yes No

If no, because of: Pain Weakness Stress

Can you go to sleep without problems? Yes No

Do you awaken because of pain? Yes No

Did you have sleep problems before? Yes No

Activities of Daily Living

Please select **all** activities which you are currently experiencing problems:

- | | | | | | |
|------------------------------------|--|-------------------------------------|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Tasting | <input type="checkbox"/> Smelling | <input type="checkbox"/> Eating | <input type="checkbox"/> Hearing | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Reading | <input type="checkbox"/> Typing | <input type="checkbox"/> Writing | <input type="checkbox"/> Grasping | <input type="checkbox"/> Using the toilet |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Leaning | <input type="checkbox"/> Walking | <input type="checkbox"/> Stooping | <input type="checkbox"/> Squatting | <input type="checkbox"/> Loss of sexual drive |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Twisting | <input type="checkbox"/> Carrying | <input type="checkbox"/> Lifting | <input type="checkbox"/> Pushing | <input type="checkbox"/> Restful sleeping |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Driving | <input type="checkbox"/> Sports | <input type="checkbox"/> Exercising | <input type="checkbox"/> Reclining | <input type="checkbox"/> Loss of concentration |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Riding in car | <input type="checkbox"/> Air travel | <input type="checkbox"/> Climbing | <input type="checkbox"/> Pulling | <input type="checkbox"/> Changes in personality |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Pinching | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Reaching | <input type="checkbox"/> Nervous | <input type="checkbox"/> Tactile feeling |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Holding | | | | |

INITIAL EVALUATION – Non Accident Related



Past Medical History

Please select all conditions that you have had or are currently having:

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast soreness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular Dx | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Chronic sinusitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis, Eczema/Rash | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty in swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular menstrual flow | <input type="checkbox"/> Irritable colon |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver / Gallbladder Problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Muscular in coordination | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in ankle or foot | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip | <input type="checkbox"/> Painful urination | <input type="checkbox"/> PMS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Profuse menstrual flow | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Renal disease | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling/stiffness joints | <input type="checkbox"/> Thyroid disease of |
| <input type="checkbox"/> Tinnitus/ear noises | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Wrist pain | <input type="checkbox"/> Other | | | |

Family History

Please select all conditions that run in your family:

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Weight Gain/loss | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Aortic aneurysm | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast soreness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiovascular Dx | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> COPD | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatitis, Eczema/Rash | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fainting | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Gout | <input type="checkbox"/> Hand pain | <input type="checkbox"/> Headache | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HBP | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High PSA | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Irregular menstrual flow | <input type="checkbox"/> Irritable colon |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Kidney disorders | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Liver/Gallbladder problems | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Loss of bladder control | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Mental disease | <input type="checkbox"/> Mid back pain |
| <input type="checkbox"/> Muscular coordination | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Pain in ankle or foot | <input type="checkbox"/> Pain in lower leg or knee |
| <input type="checkbox"/> Pain in upper arm or elbow | <input type="checkbox"/> Pain in upper leg and hip | <input type="checkbox"/> Painful urination | <input type="checkbox"/> PMS | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Profuse menstrual flow | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Renal Dx | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Swelling/stiffness of joints | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Tinnitus/ear noises | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Wrist pain | Other: | | | |

Surgical History

Please select all surgeries that you have had in the past.

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal Exploration | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> ACL Reconstruction | <input type="checkbox"/> Adenoid Removal | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bone Fracture Repair |
| <input type="checkbox"/> Breast Lump Removal | <input type="checkbox"/> Bunion Removal | <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Cervical Spine Surgery |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Cosmetic Breast Surgery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Facelift | <input type="checkbox"/> Gallbladder Removal |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemorrhoid Surgery | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Hip Joint Replacement | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Knee Joint Replacement |
| <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> LASIK Eye Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Lumbar Spine Surgery | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Prostate Removal | <input type="checkbox"/> Rotator Cuff Surgery | <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Surgical History was reviewed:
Not contributory | | Other: | | |

Medications

Please select all medications that you are currently taking:

- | | | | | |
|---|--|-------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Antacids | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Daily Vitamins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion | <input type="checkbox"/> Heart | <input type="checkbox"/> Muscle Relaxers | |
| <input type="checkbox"/> OTC | <input type="checkbox"/> Pain | <input type="checkbox"/> Steroids | <input type="checkbox"/> Thyroid | Other: |

Allergies

Please select all items that you are allergic to:

- | | | | |
|-------------------------------|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Chemical | <input type="checkbox"/> Environmental |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medication | <input type="checkbox"/> Seasonal | Other: |

Social History

Please answer the following questions:

- | | | | | |
|----------------------------------|--|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated |
| Do you have any children? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, how many? _____ | | |
| Do you use: | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Coffee | |