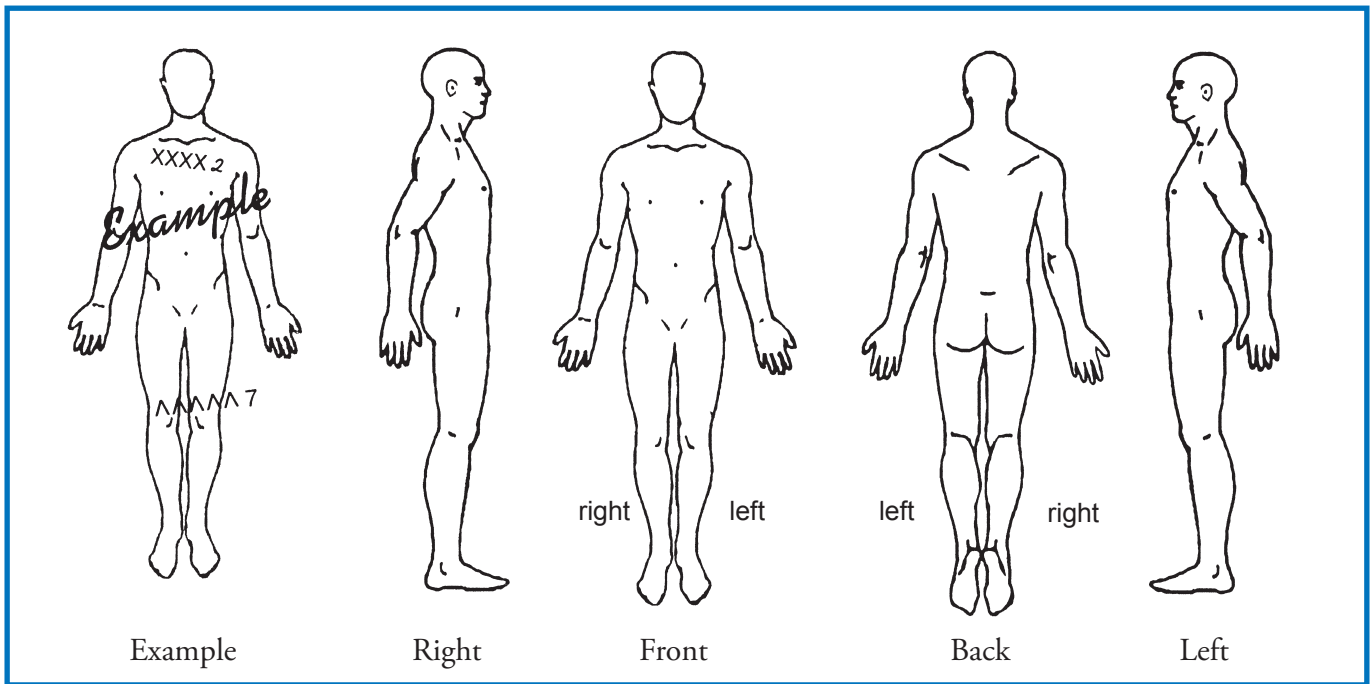


Pain Drawing

Date: _____ Patient Name: _____

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (mild discomfort) to 10 (extreme pain).

 Numbness Pins & Needles Burning Aching Stabbing
 ----- OOOOO ^^^^^ XXXXX ●●●●●



No Pain | _____ | Worst Possible Pain

Please make a slash through the above line as to the level of your pain.

Dear Patient:

Please be advised that all treatment recommendations made in this office are individualized and constructed in the best interest of your health and wellness. Kindly read and sign the following:

Financial Responsibility

Patient Name (print): _____

Assignment of Insurance Benefits: I authorize and direct that payment be made directly to: **Dr. John T. Cece, 71 Franklin Turnpike, Suite #5, Waldwick, New Jersey 07463**, for any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

Date: _____ Patient Signature: _____

Release of Information: I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or medicare.

Date: _____ Patient Signature: _____

Payment Agreement: I understand that my medical insurance is a contract between me and my insurance carrier, and that the benefits quoted by my insurance carrier are not a guarantee of payment and are subject to review based on the terms of my individual contract. Notwithstanding claim denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges for treatment in this office.

Date: _____ Patient Signature: _____

Full Name: _____ Email Address: _____ Date: _____
 Social Security Number: _____ Date of Birth: _____ Age: _____ Male Female
 Spouse/Significant Other: _____ Date of Birth: _____ Social Security Number: _____
 Children's Name and Ages: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
 Employer: _____ Employer Address: _____
 City: _____ State: _____ Zip: _____ Emergency Name and Number: _____
 How did you hear about the doctor? If someone referred you, what is their name? _____
 Is there a specific reason for consulting our office at this time? _____

YOUR HEALTH PROFILE

As a full spectrum chiropractic office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

YOUR ADULT YEARS

	YES	NO	UNSURE	COMMENTS
Do you drink water daily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much: _____
Do you drink caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much: _____
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much: _____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much: _____
Any surgeries/hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take any supplementals/vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What kind/which brand: _____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
On a scale of 0-10 describe your stress level (0=none / 10=extreme):				Occupational _____ Personal _____
On a scale of Poor-Good-Excellent describe your:				Diet _____ Exercise _____ Sleep _____ General Health _____
Have you ever: Bought bottled water:	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Belonged to a health club: <input type="checkbox"/> YES <input type="checkbox"/> NO	

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no specific symptoms or complaints, and you are here for Chiropractic Wellness Services please (X) here _____ and skip to the Family Profile section of this form. All others please briefly describe your chief area of complaint:

include the effect it has had on your life:

Yes, it interferes with... Work Sleep Walking Sitting Hobbies Leisure

If you are experiencing pain, is it... Sharp Dull Comes and goes Travels Constant

Since the problem started, it is... About the Same Getting Better Getting Worse

What makes it worse? _____

Other Doctors seen for this problem (please list):

Chiropractors _____

Medical Doctors/Other _____

Please check (X) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins and Needles in Leg | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fever | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Buzzing in Ear | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Menstrual Irritability | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Mood Swing | <input type="checkbox"/> Eyes Sensitive to Light |

List any medications you are currently taking: _____

FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your...

Children _____

Spouse/Partner/Significant Other _____

Parents _____

Siblings _____

Others _____

The statements made on this form are accurate to the best of my knowledge.

Signature _____ Date _____