Henning Chiropractic
35 Hwy 31
Flemington, New Jersey 08822
908-751-5706 (phone) 908-751/5708 (fax) henningchiropractic1@verizon.net

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ **Today's Date:** ___/___/___

Birth Date: ___/___/___ Age: ____ Gender: F M Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

ADDRESS:

Street _____

City _____ State _____ Zip _____

Phone (_____) _____ Cell (_____)_____ email_____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

Date of last physical examination? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

_____

Patient Questionnaire – Auto-Accident

Patient Name:_____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient☐ Yes ☐ No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the:☐Driver ☐Passenger ☐Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car:☐Front☐Rear☐Pedestrian☐Driver Side☐Passenger Side☐Bumper☐Fender

Damage Amount Estimate: $_____ :☐Minor☐Major☐Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐Front ☐Rear ☐Pedestrian ☐Driver Side ☐Passenger Side ☐Bumper ☐Fender
☐Minor ☐Major ☐Totaled

Where did the accident happen?Street Names: _____ City/State _____

Was it? ☐Controlled Intersection☐Uncontrolled☐Not Intersection

Was there a traffic light? ☐None☐Green☐Red☐Turn Arrow☐Stop Sign

Were you:☐Slowly Moving☐Moving☐Stopped

Weather Conditions: ☐Sunny☐Rainy☐Cloudy

Street Surface:☐Dry☐Wet☐Slick ☐Icy☐Pavement☐Other _____

Type of Impact: ☐Rear end☐Front☐Side Impact☐Roll Over

Brakes on Impact: ☐Locked Tight☐Loosely Applied☐Foot not on brake

How far did your car move?☐Did not move ☐Moved 1-5 ft☐Moved 6-10 ft☐Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐Up☐ Down

Is the car equipped with airbags?☐ Yes ☐NoDid they deploy?☐ Yes ☐ No

Did you see the impact coming?☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐Ahead☐Behind☐Up☐Down☐To the Right☐To the Left

On impact were you: ☐Thrown forward☐Thrown backwards☐Thrown sideways☐Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐Neck ☐Mid-back ☐Low-back ☐Other X-rays _____

Medication Given? ☐ Yes ☐ No RX: _____

Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: ☐Burning ☐Sharp ☐Dull ☐Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar conditionor symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐Headache	☐Dizziness	☐Light Bothers Eyes	☐Diarrhea	☐Head seems too heavy	☐Neck Pain
☐Loss of Memory	☐Clumsiness	☐Feet Cold	☐Neck Stiff	☐Tingling in arms/hands	☐Ears Ring
☐Hands Cold	☐Sleeping Problems	☐Tingling in legs/feet	☐Face Flushed	☐Nausea	☐Back Pain
☐Numbness in arms/hands	☐Buzzing in Ears	☐Constipation	☐Nervousness	☐Numbness in legs/feet	☐Loss of Balance
☐Cold Sweats	☐Tension	☐Shortness of Breath	☐Fainting	☐Fever	☐Fatigue
☐Irritability	☐Loss of Smell	☐Chest pain/rib pain	☐Pain in arms/hands	☐Pain in legs/feet	☐Jaw pain
☐Loss of strength - arms	☐Burning muscle pain	☐Loss of strength - legs	☐Difficulty swallowing	☐Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐Eyes (sight)	☐Ears (hearing)	☐Nose (smell)	☐Mouth (taste)	☐Bladder
☐Bowels	☐Sleep	☐Emotion	☐Appetite	

Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke?☐ Yes ☐No Number of packs: _____

Do you drink alcohol?☐ Yes ☐No Number of Drinks _____

Notes:_____

_____

_____

_____

Medical History:

Have you ever beenin our office before?☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ __/__/__

2) _____ __/__/__

3) _____ __/__/__

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

☐Heart Disease	☐Diabetes	☐Cancer	☐Stroke	☐High Blood Pressure	☐Thyroid Problems
☐Tuberculosis	☐Prostate Disorder	☐Kidney Problems	☐Asthma	☐Ulcer	☐Seizure Disorder

Other: _____

Right Handed_____ **Left Handed**_____

Vitals: Height_____ **Weight:**_____ **B/P:**_____

Dr. Gunnar M. Henning DC

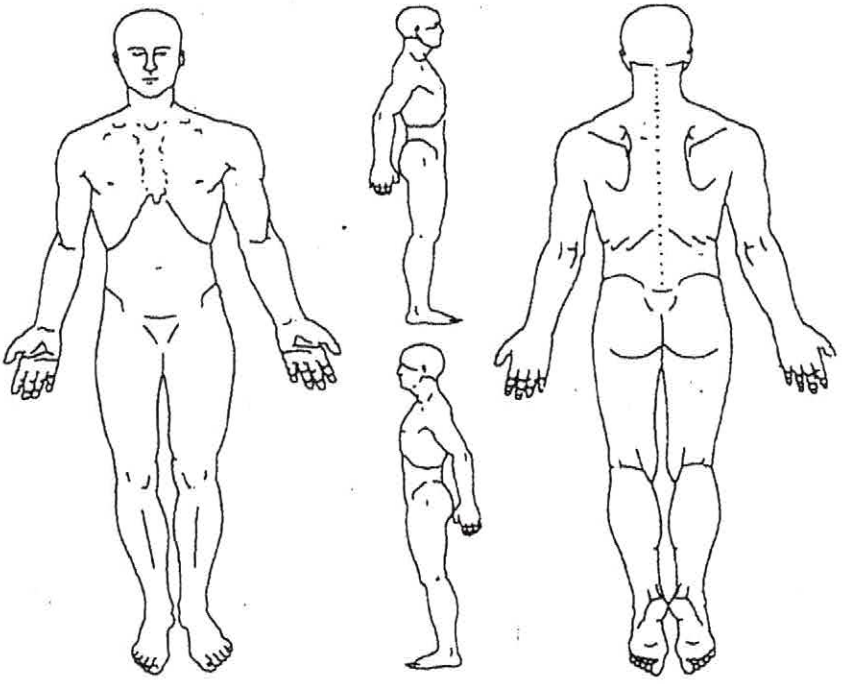
Chiropractic Physician
Est. 1982

35 Hwy 31
Route 31
Flemington, NJ 08822

Phone: 908-751-5706 Fax: 908-751-5708 henningchiropractic1@verizon.net

Name_____

DATE _____



USE THE LETTERS LISTED BELOW TO INDICATE
THE *TYPE* AND *LOCATION* OF YOUR PAIN & SENSATIONS...

KEY

A = ACHE	B = BURNING	S = STABBING
N = NUMBNESS	P = PINS & NEEDLES	O = OTHER

_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's
Signature _____ Date: _____

CLAIM NO.

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

IMPORTANT:

1. **TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW YOU MUST COMPLETE AND SIGN THIS FORM.**
2. **YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION (S).**
3. **RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.**

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT

TO: _____
CLAIMS DEPARTMENT

FOLD HERE

YOUR NAME	PHONE NO. HOME / BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / / / SOCIAL SECURITY NO.
DATE AND TIME OF ACCIDENT / / AM PM	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
BRIEF DESCRIPTION OF ACCIDENT	

ARE THERE OTHER AUTOS IN YOUR HOUSEHOLD? ☐ YES ☐ NO

IF YES, LIST:

OWNERS	INSURERS	POLICY #

WERE YOU THE DRIVER OF THE AUTOMOBILE?	YES ☐	NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE?	YES ☐	NO ☐
WERE YOU A PEDESTRIAN?	YES ☐	NO ☐
WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD?	YES ☐	NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS **YES**, COMPLETE THE REST OF THIS FORM.
IF **NO**, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL, WERE YOU ☐ AN IN-PATIENT? ☐ AN OUT-PATIENT?	HOSPITAL'S NAME AND ADDRESS
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSES? YES ☐ NO ☐
	WERE YOU ON WORK TIME WHEN THE ACCIDENT OCCURRED? YES ☐ NO ☐
HEALTH INSURANCE CARRIER:	MEMBER NAME:
POLICY #:	GROUP #: / CLAIMS PH #:
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $ / WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN / /	DATE YOU RETURNED TO WORK / /

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER:

	YES	NO	
(1) ANY WORKERS' COMPENSATION LAW?	☐	☐	IF YES, AMOUNT
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐	$ _____
(3) MEDICARE?	☐	☐	PER WEEK ☐ PER MONTH ☐

LIST THE NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO. IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

Continued on Reverse

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"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal prosecution and civil penalties."

SIGNATURE: _____ DATE: _____

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW. THIS AUTHORIZATION SHALL REMAIN VALID FOR THE DURATION OF THE CLAIM. I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION FORM.

SIGNATURE _____ DATE

DO NOT DETACH

AUTHORIZATION FOR WAGE & SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE _____ DATE

SOCIAL SECURITY NO. _____

AC-PIP-1J (4/19)