Henning Chiropractic

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

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/___

Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO

If yes, who is the employer? _____

Patient Questionnaire – Non-Accident

General Information Related to the Condition:

Approximately when did the conditions or symptoms begin to occur?___/___/___ ☐No particular symptoms -- Just seeking general good health

Describe the conditions, symptoms or purpose of the appointment:

_____

_____

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 condition previous to this most recent occurrence? ☐ Yes ☐ No When? ___/___/___

Describe: _____

Please indicate 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

Medical History:

Have you ever been in 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) _____ ___/___/___

Surgeries/Hospitalizations: _____

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_____

Dr. Gunnar M. Henning DC

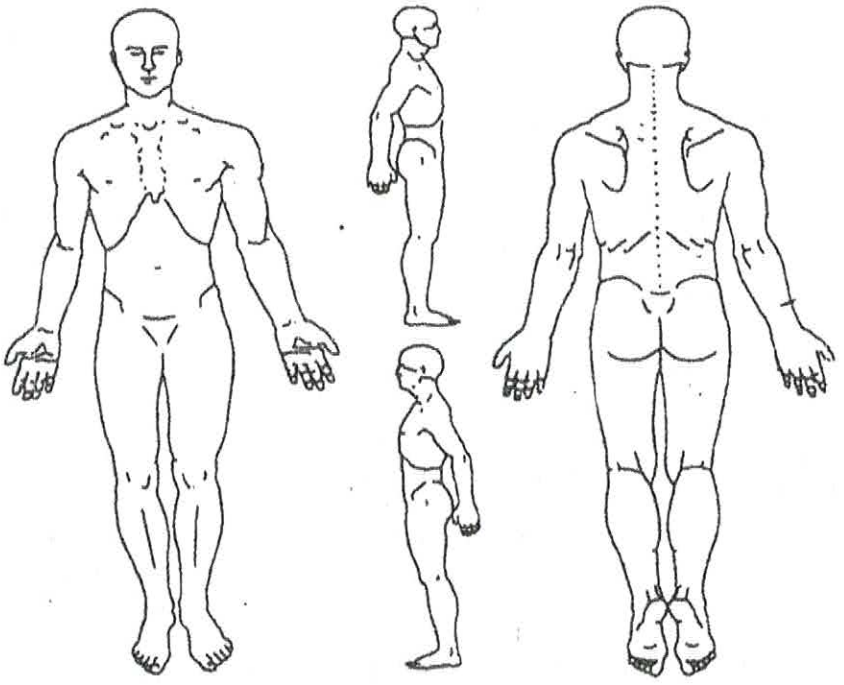
Chiropractic Physician
Est. 1982

101 Pennsylvania Ave
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)

Right handed_____ Left handed_____

Smoker yes_____ no_____

Drink alcohol yes_____ no_____

Height:_____ Weight:_____ B/P _____

Shoe size:_____ width: Regular:_____Narrow:_____ Wide:_____

Dr. Gunnar M. Henning DC

Chiropractic Physician
Est. 1982

101 Pennsylvania Ave
Route 31
Flemington, NJ 08822

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

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): _____

Form # PRV1-3

Henning Chiropractic
101 Pennsylvania Ave
Flemington, New Jersey 08822
908-751-5706 (phone) 908-751/5708 (fax) henningchiropractic1@verizon.net

****

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: _____