Date________________________

Name ____ Birth Date_______/_______/_______

Home # ____________________ Cell# _______________________ Email _____________________________

Address ____ Apt# ____________________

City _________________ State _________________ Zip Code ______________ Marital: **M S W D**

Employer _______________________________________ Occupation _________________________

Address _______________________________________ Work Phone _________________________

Name of Insurance Company____________________________________ Insured name

____

Secondary Insurance ____ Insured name ____

Relationship to Insured ____

Emergency Contact ___________________________________ Phone Number ____________________________

Is this a worker's compensation case, a motor vehicle accident case? ☐ YES ☐ NO ______ Initials

Date symptoms appeared or accident occurred _________________________________

Primary Care Physician Name ____ **Physician Office Number**__________________________

Have you lost any days from work? _____________________

Date of last physical exam ____________________________

Purpose of this appointment (Major Complaint)

____

____

What aggravates your discomfort?____

What relieves your discomfort?____

Have you had this condition before ☐ **YES** ☐ **NO** **If yes, when:** ____

Is this condition interfering with the following? ☐ Work ☐ Daily Routine ☐ Sleep ☐ Other tasks______________________________

Please rate your current discomfort 0 - 10 (10/10 being most severe) 0 1 2 3 4 5 6 7 8 9 10

What is the frequency of your discomfort? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Have you been treated by a Medical Doctor/Chiropractor/Physical Therapist/Acupuncturist for this condition? ☐ Yes ☐ No

If yes, by who?____

<u>**Personal Health History**</u> Height _____ Weight _____

Allergies: ____ Reaction: ____

Major Hospitalization/Infections/Trauma: ____

Current Medications: ____

Injury History/Surgeries: ☐ Neck/Back ☐ Shoulder ☐ Elbow ☐ Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Other:

____

Family History Check & Circle all of the following that apply to your FAMILY MEMBERS (Mother/Father/Brother/Sister):

☐ Cancer: M / F / B / S List Type(s): ____________________

☐ Heart Disease: M / F / B / S

☐ Blood Pressure: M / F / B / S

☐ Diabetes: M / F / B / S

☐ Arthritis/Rheumatoid Arthritis: M / F / B / S

☐ Neurological Disorder: M / F / B / S

☐ Autoimmune Disorder: M / F / B / S

☐ Stroke: M / F / B / S

Have you ever suffered from the following: Check all that apply

Constitutional
__ Weight Loss
__ Weight Gain
__ Loss of Appetite
__ Recent Fever/Chills
__ Fatigue
__ Cancer:__________
__ Change in Bowel or Bladder Function
__ Fainting or Loss of Consciousness
__ Recent Falls

Skin
__ Frequent Rashes
__ Open Wounds
__ Skin Lesion
__ Itchy/Red Skin
__ Skin Cancer

Eye
__ Blurred Vision
__ Vision Loss
__ Double Vision

ENT
__ TMJ / Jaw Pain
__ Nose Bleeds
__ Hearing Loss
__ Ringing Ears
__ Hoarseness/Sore Throat
__ Difficult Swallowing
__ Sinus Infections

Lung/Respiratory
__ Short of Breath
__ Wheezing
__ Chronic Cough
__ Exercise Intolerance
__ Asthma

Cardiovascular
__ Chest Pain
__ Irregular Beat
__ Calf Pain
__ High Cholesterol
__ High Blood Pressure
__ Pacemaker/Stents

Digestive
__ Heartburn
__ Nausea/Vomiting
__ Blood in Stool
__ Liver/Gallbladder

Kidney/Bladder
__ Painful Urination
__ Problems Urinating
__ Incontinence
__ Kidney Stones
__ Kidney Problems
__ UTI
__ Dialysis

Glands
__ Excessive Thirst
__ Frequent Urination
__ Diabetes
__ Always Hot/Cold
__ Thyroid problems
__ Swelling

Blood
__ Anemia
__ Easy Bruise/Bleeding
__ Clotting Disorders
__ Blood Transfusion

Neurological
__ Headaches
__ Migraines
__ Dizziness
__ Vertigo
__ Weakness
__ Change in Sensation
__ Epilepsy
__ Stroke
__ Concussion

Skeletal
__ Arthritis
__ Osteoporosis
__ Broken Bones
__ Painful Joints
__ Sports Injury

Psychiatric
__ Drug/Alcohol Abuse
__ Depression
__ Anxiety
__ Phobias

Male Reproductive
__ Erectile Dysfunction
__ Prostate Problems
__ Dribbling Urine
__ Low Testosterone
__ Infections/STDs
__ Discharge
__ Pain in genitals

Female Reproductive
Last cycle: __________
__ Pregnancies #_____
__ Pain/Discharge
__ Yeast Infections
__ Birth Control or Hormone Replacement
__ Irregular Cycles
__ Post-Menopause

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports or forms to assist me making collections from the insurance company and then any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered are to be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

In accordance with Education Law section 6731 (d), a physical therapist providing treatment in the practice of physical therapy without a referral from a physician, dentist, podiatrist, or nurse practitioner, in accordance with Education Law section 6731 (d) and the requirements of this section shall advise the patient in writing prior to beginning treatment of the possibility that treatment may not be covered by the patient's health care plan or insurer without a referral from a physician, dentist, podiatrist, or nurse practitioner and that treatment may be a covered expense if rendered pursuant to such referral For your convenience we have a medical doctor on staff that can evaluate you and prescribe physical therapy if necessary.

I have been given the opportunity to review the HIPAA Patient Privacy Policy

Patient Signature ______________________________________ Date ________________

Guardian or Spouse's Signature Authorizing Care ____________________ Date ________________

BACK & BODY PAIN RELIEF, P.C.

SHAN SIVENDRA, M.D. • ROSS NOCHIMSON, D.O. • DAVID PERNA, D.C., C.C.S.P., C.C.E.P.
• ROBERT MINLIONICA, D.C., C.C.S.P., M.P.A., A.T.C. • NEELKUMAR PATEL, P.T., M.S., D.P.T., C.C.I.
• EILEEN EGAN-RUSSO, LA.C. • GENEAN BERRY, L.A.C.

355 US 22 EAST, STE. D SPRINGFIELD, N.J. 07081
PHONE: 908-325-3000 FAX: 908-325-3232

Back and Body Pain Relief
Release and Consent to Photograph and Publish

The undersigned hereby authorizes Back and Body Medical to photograph (print patient name)

________________________________ under the care of Back and Body Medical.

Scope of consent. The undersigned agrees that Back and Body Medical may use this photograph (s), written testimonials, audio, and transcripts for any and all purposes including, but not limited to, art, advertising, promotional, educational and medical office books and presentation used for patient decision-making and in all media, including electronic, digital and print media and that such distribution may be accomplished in a any matter and that such use is subject only to the following limitations.

Term. This release and consent shall remain in effect until rescinded at any time in accordance with the following "Notice and Termination Use" provision below, and some use may continue after that time, but only as provided in the "Notice and Termination Use."

Notes and Termination of Use. This release and consent may be rescinded at any time in accordance with the terms of this "Notice of Terms of Use" provision. Rescission of this consent must be in writing, requesting discontinuation of use of photographs, written testimonials, audio, and transcripts taken while under the care of Back and Body Medical. After receiving the written request, Back and Body Medical may continue using the photographs, written testimonials, audio, and transcripts until the existing inventory is depleted, or for television commercials, videos or similar materials, may continue using the photographs until as long as they were intended to be used at the time they were created. Back and Body Medical will not reprint existing materials or create new advertising or other materials incorporating the photographs unless otherwise allowed to do so under this "Notice and Termination of Use" provision.

Waiver. Except as specifically stated above. I hereby waive any and all other rights I may have in respect to any photographs taken of me by Back and Body Medical and all images created from them in accordance with the release and content. Without limiting the generality of the foregoing, I specifically waive any rights I may have had to be paid or otherwise compensated for the use of such photographs, and any rights I may have to inspect or approve the finished photographs, images, printed matter that that may be used in conjunction with any photographs taken of me.

Entire Agreement: This release and consent constitutes the sole agreement between Back and Body Medical and myself regarding my photographs and I am not relying on any other oral or written representation made by Back and Body Medical.

Release: The undersigned hereby releases and holds Back and Body Medical harmless from and against any claim or injury or compensation resulting from the activities authorized by this release and consent.

________________________________ ________________________________

Patient name (print) Patient signature

BACK & BODY PAIN RELIEF, L.L.C.

CONSENT TO TREATMENT

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear. We reserve the right to change the terms of this notice.

I HEREBY REQUEST AND CONSENT to performance of Chiropractic, Physical Therapy, Acupuncture & Medical procedures, including but not limited to various modes of physical medicine, therapies, joint manipulation on me by the licensed physician. The patient may refuse treatment at any time.

As a part of the examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing and muscle strength testing.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation, soft tissue therapy, therapeutic exercise, acupuncture and medical care. I understand and am informed that in the applicable methods of treatment, there are some risks, including fracture, disc injuries, strokes, dislocations and sprains. I do not expect the physician(s) or other provider(s) to be able to anticipate and explain all the risks and complications, and I wish to rely upon the physician(s) or other provider(s) judgment during the course of the treatment or procedure, given the facts known then to him or her, acting in my best interest. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Below is a list of some treatments that are offered in this office and their potential associated risks. This information is non-exhaustive of all possible outcomes. Prior to any treatment a physician will evaluate to determine the most appropriate treatment option(s) for your case and to screen for any contraindications. Any increase in symptoms, or development of new symptoms should be reported to the physician as soon as possible.

Spinal/Extremity Adjustments - The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare. A common side effect to chiropractic adjustments is some stiffness or soreness after the treatment. It may be recommended to use ice or heat packs to help with this discomfort.

Acupuncture - I understand that acupuncture is performed by the insertion of single use of sterile needles through the skin, to normalize the body's physiological functions. Acupuncture is typically a safe method of treatment however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Electric Muscle Stimulation - An electrical current is transmitted via electrodes into the skin, muscles and surrounding tissues. A small defect in the electrode coating (not always detectable by observation) may concentrate the current in one area, and cause a small burn to the skin. Additionally, the electric stimulation causes the muscles to contract, which could cause a cramp in rare circumstances. During this therapy, you will be asked if you are comfortable; if you are experiencing a sting or burn or discomfort, voice this immediately.

Electro Acupuncture - I understand that I may be asked to have electro-acupuncture administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. I do not expect the attending Licensed Acupuncturist to be able to anticipate and explain all possible risks and complications of treatment.

Therapeutic Exercises, Neuromuscular Re-education/Gait Training - This therapy involves using exercises to improve range of motion, strengthen or stabilize the structures that support your musculoskeletal system. These exercises will be dependent on your case, but may cause an increase in heart rate and may require body movements that you are not accustomed to. A common side effect to therapeutic exercise is some soreness during or after the treatment, which is not harmful, but part of the healing process. It may be recommended to use ice or heat packs to help with this discomfort, and to drink plenty of water following treatment. Risks associated with exercises include, but are not limited to: sprains, strains, fractures, dislocation, and rarely heart problems.

Manual Therapy - This therapy involves treating the associated soft tissues that may complicate your condition, by using the doctor's or therapist's hands, plastic or metallic instruments and lotion or emollients. The risks associated with manual therapy include, but are not limited to, dislocations and sprains, bruising, swelling, redness of the skin, and strokes. These negative effects are very rare. A common side effect to manual therapy is some stiffness or soreness after the treatment, which is not harmful, but part of the healing process. It may be recommended to use ice or heat packs to help with this discomfort, and to drink plenty of water.

Pregnancy - I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so my practitioner can avoid points that could induce miscarriage. If you are pregnant or trying to become pregnant, we will require clearance from your obstetrician before treatment.

Other treatment options for your condition may include: Self-administered, over-the-counter analgesics and rest, Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, Hospitalization and Surgery. If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

I HAVE READ, or have had read to me, the above consent of some of the treatment options offered. I **CERTIFY** that all information provided to this office is true and correct, to the best of my knowledge, and will have the opportunity to discuss the nature of my case, including treatment, procedures and other options. I have discussed it with the physician and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I intend this consent form to cover the entire course of treatment for my present condition, and for any future condition(s) for which I seek treatment.

Patient Signature **Date Signed**

____________________ ____________________