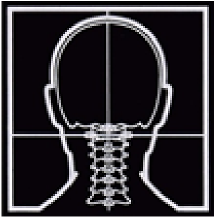


ADVANCED WELLNESS OF WESTFIELD
439 CENTRAL AVENUE
WESTFIELD, NJ 07090
PHONE: 908.228.5911
FAX: 908.228.5913
WWW.ADVANCEDWELLNESSOFWESTFIELD.COM

Date___________ Patient #___________

Patient Information

Name_____________________________________ Address____

City_____________________________________ State______________ Zip/Postal Code__________________

Birth Date ________ Age_____ Sex [ ] M [ ] F Weight: __________ Height: __________

Social Security #____________________________ Circle One: Married Single Widowed Divorced Separated

Employment Status___________________________ Occupation_____________________________________

E-Mail Address______________________________ Referred To This Office By________________________

Home Phone_________________________________ Mobile Phone/Provider___________________________

Business Phone______________________________ Circle One for Appointment Reminders: Text or Email

Name of Spouse_____________________________ Spouse's Employer______________________________

Type of Work________________________________ Name and Ages of Children_______________________

Name/Number of Emergency Contact______________________________________ Relationship_________________

Who is Responsible for Your Bill, You and [ ] Spouse [ ] Workers' Comp [ ] Auto Insurance

Health Insurance Company Name____

Name of Insured____ Insured Date of Birth_________________

Relationship to Insured____________________________________

Any Other Insurance Coverage Information____

Current Health Condition

Purpose of This Appointment____

Other Doctors Seen For This Condition? [ ] Yes [ ] No Who?____

Type of Treatment____________________________________Results______________________________________

When Did This Condition Begin?________________________Has This Condition Occurred Before? [ ] Yes [ ] No

List Any Medication You Are Currently Taking____

____

Is Patient Pregnant? [ ] Yes [ ] No Do You Take Vitamins? [ ] Yes [ ] No Do You Wear Shoe Lifts? [ ]Yes [ ]No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?______________________

List all major accidents or falls:____

____

____

____

____

Patient Health History

Please check and Describe:

Major Surgery/Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gall Bladder [ ] Hernia [ ] Back Surgery [ ] Broken Bones

Other:____

Hospitalization (Other than Above)____

Date of last chiropractic visit: ______________ [ ] None Doctor's Name_______________________________________

Please Check All the Following That Apply:

[ ] Allergies/Hay Fever	[ ] Poor Posture	[ ] Pacemaker	[ ] Blood clots	[ ] Detached Retina
[ ] Sciatica	[ ] Bruise Easily	[ ] Tuberculosis	[ ] Itching	[ ] Dizziness
[ ] Swollen Joints	[ ] Bed Wetting	[ ] Varicose Veins	[ ] Fatigue	[ ] Nosebleeds
[ ] Loss of Sleep	[ ] Diarrhea/Constipation	[ ] Headache	[ ] Colon Trouble	[ ] Frequent Urination
[ ] Indigestion	[ ] High Blood Pressure	[ ] Sinus	[ ] Kidney Stone/Infection	[ ] Ulcers
[ ] Heartburn	[ ] Pain Over Heart	[ ] Low Blood Pressure	[ ] Prostate Trouble	[ ] Numbness
[ ] Bursitis	[ ] Asthma	[ ] Nervousness/Depression	[ ] Cramps or Backache	[ ] Arthritis
[ ] Hemorrhoids	[ ] Colds	[ ] Rapid Heartbeat	[ ] Poor Circulation	[ ] Arrhythmias
[ ] Nausea	[ ] Deafness	[ ] Slow Heartbeat	[ ] Stroke	[ ] Hot Flashes
[ ] Foot Trouble	[ ] Ear Noises	[ ] Chest Pain	[ ] Difficult Breathing	[ ] Irregular Cycle
[ ] Low Back Pain	[ ] Ears Stopped Up	[ ] Pleurisy	[ ] Swelling of Ankles	[ ] Lumps in Breast
[ ] Thrombophlebitis	[ ] Eye Pain	[ ] Cancer	[ ] Diabetes	[ ] Venereal Disease
[ ] Neck Pain/Stiffness	[ ] Acute Phlebitis		[ ] Polio [ ] Failing Vision	[ ] Enlarged Thyroid
[ ] Excessive Menstrual Flow		[ ] Allergy to Cold	[ ] Raynaud's phenomenon	

Tingling or Stiffness In: [ ] Shoulders [ ] Hips [ ] Arms [ ] Legs [ ] Elbows [ ] Knees [ ] Hands [ ] Feet

---

Patient Habits

Do You Exercise Regularly? [ ] Yes [ ] No   Do You Use an Orthopedic or Cervical Pillow? [ ] Yes [ ] No

Are You Wearing? (Please Check All That Apply) Heel Lifts_____ Sole Lifts_____ Inner Soles_____ Arch Supports_____

Please Check All That Apply:

	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Assignments of Benefits

I acknowledge that I am wholly responsible for my total health care bill. For the services rendered, I hereby assign all my medical benefits available for the services to the undersigned doctor of chiropractic, and I also authorize the information necessary to process this claim to be released to the company processing the claim. Photocopies of this assignment are considered to be true and correct as the original agreement drafted by both doctor and patient.

Signature of Patient____ Date_______________________

Responsible for Bill____ Date_______________________

Patient's Permission to Treat_____________________________________ Date_______________________

Permission to Treat Child____ Date_______________________

ALL X-RAYS TAKEN ARE FOR IN-OFFICE USE ONLY. If this is an auto accident case and patient's insurance company or attorney does not settle this case within one year of the accident date the patient will be responsible for any and ALL charges that have accrued.

COMPLAINT:

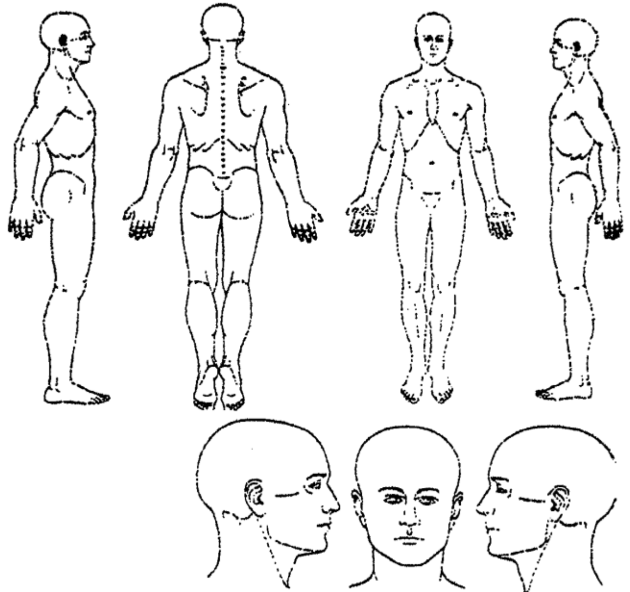
Major Secondary Tertiary Other

____

Patient Name

________________________________ Please mark area of this complaint on figures below

____



Date when symptom first appeared____________________

Is the result of an accident? ○ No ○ Yes Date:__________

If Yes, ○Work ○Auto Accident ○Home

○Other:________________________________

____

Has a Report been filed? ○Yes ○No

How often do you experience the symptoms?

○Constant (100% of time) ○Frequent (75% of time)

○Intermittent (50% of time) ○Occasional (25%) ○Rare (10%)

How many days of the month do you feel it (out of 30)?_____

How many hours of the day do you feel it (out of 24)?______

When? ○Morning ○Afternoon ○Evening ○Night

What increases symptom?______________________________

____

What relieves symptom?______________________________

____

Type of Pain:

○Sharp ○Dull ○Aching ○Burning

○Throb ○Numb ○Other________________________________

Does it radiate? ○No ○Yes Where?______________________________

Rate how it is now (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

Rate how it is on average (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

Rate how it is at its worse (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

Rate how it is at its best (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

How does this symptom affect you're:

Work?________________________________

____

Home life?________________________________

____

Leisure activities?________________________________

____

Sleep?________________________________

____

○ Additional notes on back of sheet.

________________________________ ____________________

Patient Signature Date

Current Information

Primary Physician Name: ____

Address: ____

Phone Number: ____

Email Address: ____

Psychologist's Name: ____

Address: ____

Phone Number: ____

Email Address: ____

Dentist's Name: ____

Address: ____

Phone Number: ____

Email Address: ____

Other Doctor: ____

Address: ____

Phone Number: ____

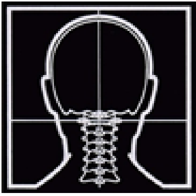
Email Address: ____

Attorney Name: ____

Address: ____

Phone Number: ____

Email Address: ____



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Re-Exam/X-Rays

1. **Federal BCBS and some other insurance companies will only pay for one exam and one set of x-rays per calendar/benefit year.**
2. **We cannot guarantee the above stated service(s) to be covered or non-covered.**
3. **We require a post x-ray following your first adjustment to make sure we have proper placement of the C-1 (atlas).**
4. **Re-exams are done every 9-16 visits throughout your care in our office.**
5. **This agreement will be binding until the treatment plan is completed to its' fullest which will include Active, Supportive, Strengthening, Maintenance Phases.**
6. **We do offer a medical discount plan to help with such services, please ask today.**

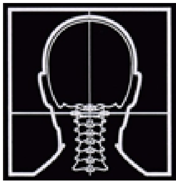
Service Description	Estimated Cost
Re-Exam____	$200_________
Subsequent X-ray__________________________________	$200_________
____	____________

_______ I understand that my insurance may not cover re-exams and/or subsequent x-rays
(Initial) due to reasons listed in item #1 above. I agree to be financially responsible for the full cost of re-exam and/ or subsequent x-rays.

By signing below, I am stating that I fully understand this agreement concerning re-exams and subsequent x-rays.

Signed____ Date___________

Witness____ Date___________



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Office Policy

We believe that a clear definition of our office policies will allow the patient, the Doctor, and the staff, to concentrate on the primary goal - HELPING YOU AND YOUR FAMILY REGAIN AND MAINTAIN MAXIUM HEALTH NATURALLY!

Appointments

- **After careful consideration of your history, examination and x-ray findings, the Doctor will recommend a care plan designed for your individual needs.**
- It is important to follow this care plan in order to maximize the healing process and to maintain optimal health.
- Our office does not "overbook" appointment times, so if you are unable to keep an appointment for any reason, we ask that you call us 24 hours in advance to reschedule your appointment. This allows us to offer the open appointment slot to someone in need. If 24 hours' notice is not given an $50 fee will be charged. We make every attempt to honor appointments at the scheduled time. If you are 10 minutes late for your appointment, please be advised you may have to reschedule or wait until the next available appointment. We will do everything possible to minimize the length of your wait.

Finances

- Your total health investment is due at the time of service. We accept cash, checks, Visa/ MasterCard/Discover, and we offer care credit.
- It is understood that this is an out of network provider. While this office will file your claim for you, it is understood that this office may offer services to you which are either not covered by your insurance or, at a future date, may be determined medically un-necessary. You, the patient, agree to be held financially responsible for these charges which will be discussed.
- We offer many affordable options for treatment. These options will be discussed at the time of your visit prior to any treatment.
- Account balances may not exceed $200 at any time.
- The health investment for your visits are ***estimated*** as follows:
  - X-rays are $400
  - First adjustment (evaluative appointment) is $ 95.00
  - Subsequent visits (adjustments and therapies) are: $85-$250.

Collections

- **Any account that is 45 days past due will be charged a monthly finance fee of 1.5%.**
- **Accounts that are 90 days past due will be sent to collections. A 35% fee will be added to the balance due at that time. This is to cover costs incurred from the collections agency. Any further visits will then be on a "cash only" basis. Any attorney's fee associated with collection of an account will be the account holder's responsibility.**

Assignment/Release

- I agree to make payment for any service rendered.
- I understand my signature requests that payments be made to Advanced Wellness of Westfield and authorizes release of information necessary to pay any claims filed. I have read, understood and agreed to the above financial policy for payment of professional fees.

____ Signature ______________ Date

Advanced Wellness of Westfield

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Our commitment at Advanced Wellness of Westfield is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all protected health information.

During the course of serving your interests it may be necessary to share information with other Heath Care Providers or Business Associates. The following are examples of instances where information may be shared:

•During care here, we may find it necessary to acquire a laboratory analysis
•For payment purposes, we may use the services of our billing service
•During health care operations, we may need a second opinion

At Advanced Wellness of Westfield, we are committed to obeying all Federal, State and local laws and regulations regarding Privacy Practices. If any uses or disclosures other than those listed above are needed, information will only be released with written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your
Protected Health Information, feel free to contact our
Office at (908)228-5911

I have read and understand the above Notice of Privacy Practices.

Signed ______________________________________

Date ________/________/________

Advanced Wellness of Westfield

Plan Progress for: ______________________________________ Start Date: ______________

Adjustments	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
	31	32	33	34	35	36	37	38	39	40
	41	42	43	44	45	46	47	48	49	50
	51	52	53	54	55	56	57	58	59	60
	61	62	63	64	65	66	67	68	69	70
Decompression	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
	31	32	33	34	35	36	37	38	39	40
	41	42	43	44	45	46	47	48	49	50
	51	52	53	54	55	56	57	58	59	60
	61	62	63	64	65	66	67	68	69	70
Therapies	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
	31	32	33	34	35	36	37	38	39	40
	41	42	43	44	45	46	47	48	49	50
	51	52	53	54	55	56	57	58	59	60
	61	62	63	64	65	66	67	68	69	70
Physical Therapy	1	2	3	4	5	6	7	8	9	10
	11	12	13	14	15	16	17	18	19	20
	21	22	23	24	25	26	27	28	29	30
	31	32	33	34	35	36	37	38	39	40
	41	42	43	44	45	46	47	48	49	50
	51	52	53	54	55	56	57	58	59	60
	61	62	63	64	65	66	67	68	69	70
Urine Test	1	2	3	4	5	6	7	8	9	10
Chair Massage	1	2	3	4	5	6	7	8	9	10

Advanced Wellness of Westfield

Insurance Verification

Patient's Name_________________________________ Patient DOB _________________

Insured Name (if different) ________________________________DOB________________

Ins CO. Name____________________________________ INS Phone #__________________

INS ID#____ Group #______________________

Policy Effective Date__________________________

Deductible: ___________________ Met? YES NO How Much?:_______________

Out of Network Benefits? YES NO

Chiropractic Covered %? __________________ #Visits/yr. ________________

Acupuncture Covered %? __________________ #Visits/yr. ________________

Physical Therapy Covered %? ______________ #Visits/yr. ________________

Any Precertification Required? YES NO

Pre-cert Contact #________________________________ Auth. #________________

Claims Mailing Address____

____

____

Additional Info: ____

Staff Member____ Date__________________

Representative Name____

Confirmation #____

Metabolic Assessment Form

Name ____________________________________ Age _______ Sex _______ Date __________________

Part 1:

Please list 3 major health concerns in your order of importance (1 being most important)

1. ____
2. ____
3. ____

Part 2:

Please circle the appropriate number (0 – 3) on all questions below to the best of your ability.

O = the least/never and **3 = most/always**

Category 1: Colon

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relief after passing stool/gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stools	0 1 2 3
Coated tongue, or "fuzzy" feeling on tongue	0 1 2 3
Pass large amounts of foul smelling gas	0 1 2 3
More than three bowel movements a day	0 1 2 3
Do you use laxatives frequently	0 1 2 3

Category 2: Hypochloridia

Excessive belching, burping, or bloating	0 1 2 3
Gas Immediately following meals	0 1 2 3
Offensive breathe	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; Undigested foods found in stool	0 1 2 3

Category 3: Hyperacidity (Ulcer)

Stomachache/pains or burning after meals	0 1 2 3
Do you frequently use antacids	0 1 2 3
Feeling hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Get temporary relief from antacids, food, milk	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy food, chocolate Citrus, peppers, alcohol, and caffeine	0 1 2 3

Category 4: Small Intestine (Pancreas)

Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2 – 4 hours after meal	0 1 2 3
Pain, soreness, or bloat under left side of ribcage	0 1 2 3
Excessive passing of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stools are undigested or foul smelling	0 1 2 3
Frequent urination	0 1 2 3
Difficulty losing weight	0 1 2 3
Increased appetite and thirst	0 1 2 3

Category 5: Biliary Insufficiency/Status

Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay color to normal brown	0 1 2 3
Reddened skin, especially palms of hands	0 1 2 3
Dry or flakey skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed	YES NO

Category 6: Hypoglycemia

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to get started, or to keep going	0 1 2 3
Get lightheaded if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, have tremors	0 1 2 3
Easily agitated, upset, or nervous	0 1 2 3
Poor memory or forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category 7: Insulin Resistant

Fatigue after meals	0 1 2 3
Eating sweets does not relieve craving for sugar	0 1 2 3
Must have sweets after meal to be satisfied	0 1 2 3
Waist girth is larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category 8: Adrenal Hypo function

cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak finger and/or toe nails	0 1 2 3

Category 9: Adrenal Hyper function

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amounts of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired, even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration with little or no activity	0 1 2 3

Category 10: Hypothyroid

Tired and/or sluggish	0 1 2 3
Feel cold in hands, feet, or all over	0 1 2 3
Require excessive sleep to function normally	0 1 2 3
Increase in weight gain, even with low calorie diet	0 1 2 3
Gain weight very easily	0 1 2 3
Difficult and/or infrequent bowel movements	0 1 2 3
Depression and lack of motivation	0 1 2 3
Morning headaches that wear off as day goes by	0 1 2 3
Outer third of eyebrows thins	0 1 2 3
Thinning of hair on scalp or other parts of the body	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category 11: Thyroid Hyper function

Heart Palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervousness and overly emotional	0 1 2 3
Insomnia	0 1 2 3
Night Sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category 12: Pituitary Hypo function

Diminished sex drive	0 1 2 3
menstrual disorders or lack of menstruation	0 1 2 3
increased ability to eat sugar without symptoms	0 1 2 3

Category 13: Pituitary Hyper function

Increased sex drive	0 1 2 3
Tolerance to sugar reduced	0 1 2 3
“Splitting” type headaches	0 1 2 3

Category 14: (Male Only) Prostate

Urination difficulty or dribbling	0 1 2 3
Urinate frequently	0 1 2 3
Pain inside legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3

Category 15: (Males Only) Andropause

Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erection	0 1 2 3
Difficulty in maintaining morning erection	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Frequent muscle soreness	0 1 2 3
Decrease in physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category 16: (Menstruating Females Only)

Alternating menstrual cycle lengths	YES NO
Extended menstrual cycle, greater than 32 days	YES NO
Shortened menses, less than every 24 days	YES NO
Pain and cramping, during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Irritable and/or depressed during menses	0 1 2 3
Acne breakouts	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss or thinning	0 1 2 3

Category 17: (Menopausal Females Only)

how many years have you been menopausal?	___________
Do you have uterine bleeding since menopause	YES NO
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful Intercourse	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3

Part 3:

How many alcoholic beverages do you consume per week? _______ How many caffeinated beverages do you consume per day? _________

How many times do you eat out per week? ________ How many times a week do you eat raw nuts or seeds? ______________

How many times per week do you eat fish? _________ How many times a week do you work out? _______________

List the three worst foods you typically eat in a week____

List the three healthiest foods you typically eat in a week____

Do you smoke? YES NO If yes, how many times per day? ____________________

Rate you stress level on a scale of 1-10 in an average week (10 being the most possible stress) ________________________

Please list any medications you currently take and for what conditions: ____