HEALTH FIRST
CHIROPRACTIC CLINICS INC.

48 S. New York Road
Galloway, NJ 08205
(609) 652-6363

The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and prevention of disease.
– Thomas A. Edison

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____
Email address: _____@_____
Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:**
_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer
Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date:_____

For office use only

Height:_____ Weight:_____ Blood Pressure:_____/_____

HEALTH FIRST
CHIROPRACTIC CLINICS INC.

48 S. New York Road
Smithville, NJ 08201
Smithville Professional Center
(609) 652-6363

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–Thomas A. Edison

Dr. J. Zimmerman, Jr.
President

ENTRANCE RECORD

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called **SUBLUXATIONS.** Subluxations come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the body to function properly and to heal itself.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and his only means is the correction of the vertebral subluxation.

Please understand that chiropractic is **NOT** a substitute for medical treatments of any kind. Also, **NO** statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effects. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive in a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice insurance costs less than his car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on you next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to the doctor. The doctor will do his utmost to care for you in the safest and most effective manner, just as he would his own family.

Please **PRINT OR WRITE CLEARLY:**

I,_____, have read the above, understand it fully and undertake Chiropractic care on this basis.

_____ _____

SIGNATURE **DATE**

Health First Chiropractic Clinics & Wellness Centers

Restoring Function, Improving Health & Enhancing Performance From Infancy To Adulthood

Dr. J. Zimmerman, D.C. – Director
Galloway, NJ 609-652-6363

Client Information

Name_____Sex: M/F Date of Birth_____Age_____

Address_____City_____State _____Zip_____

Phone#_____SS#_____Marital Status_____

Spouse's Name_____Children? Y or N Names_____

E-Mail Address_____ Your Employer_____

Job Description_____Work Phone#_____

Which One Of Our Clients Referred You to Our Practice? (or) How Did You Hear About Our Office?_____

Primary Insurance Company_____Secondary_____

Name of Insured_____DOB_____

Have you Met Your Yearly Deductible? Y or N

Do You Need A Referral From Your Primary Doctor Before Care In Our Office? Y or N_____

What Is Your Reason For Contacting Our Office?_____

_____

Is This Reason A Direct Result Of A Work Injury? Y or N

Is This Reason A Direct Result of An Automobile Accident? Y or N

Any additional Information you need to tell us. Please enter below.

_____

_____

Consent For Care

Chiropractic care consists of analyzing the spine for vertebral misalignments and making spinal corrections via the spinal adjustment. Misalignments called subluxations may exist anywhere in the spinal column with or without symptoms. Our focus as chiropractors is to detect, correct and prevent subluxations from becoming a health problem. At times, the chiropractor will adjust subluxations in the neck, middle back and lower back regardless of a person's asymptomatic state. Vertebral subluxations that are detected based on a visit to visit spinal analysis will be addressed by the doctor's spinal adjustment. The chiropractor will explain the different types of spinal adjustments to the client as it is appropriate. At any time, you the client, have the right to reject care as well as receive care. I Have Read The Above And Consent To Care As Outlined To Me.

Signed_____ Date _____

Parent Authorizing Care For Minor:

Signed_____ Date_____

Insurance Agreement

I understand and agree that health and accident insurance is an arrangement between the insurance carrier and myself. Health First Chiropractic Clinics are not agents or employees of the insurance company. Understanding My insurance policy's coverage and limitations as well as monetary Reimbursement is ultimately my responsibility. Health First Chiropractic Clinics Will prepare necessary reports, pre-certifications, forms and directly bill the Insurance company whenever possible. However, I understand and agree that All services rendered to me are charged directly to me and that I am responsible For payment if the insurance company does not pay Health First Chiropractic Clinics. I authorize the release of any information needed to process my claims And assign benefits directly to this facility.

Insured's

Signature_____ Date _____

Cash Patient Agreement

I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Cash Patient's Signature_____Date_____

Health First Chiropractic Clinics & Wellness Centers

Confidential Health History

Name_____Date_____

Vertebral subluxations are caused by physical, chemical and emotional stress. The following questions will help us identify sources of stress.

Please circle Y for yes or N for no. The doctor will talk to you about your YES answers.

1. Is there a known history of traumatic childbirth? Ex. Forceps, vacuum extraction, difficult labor. Y or N

2. Is there a history of childhood and teenage trauma? Y or N

3. Any recent trauma, accidents, strains or sprains? Y or N

4. Have you had any recent unexplained high fevers or unexplained infections? Y or N

5. Are you aware of any past or present disease conditions in your body? Y or N

6. Have you had any spinal (neck or back) surgery? Y or N

6. Do you have heart disease? Y or N High Blood Pressure? Y or N Last BP reading_____

7. Do you have a history of carotid artery problems? Y or N Do you Smoke? Y or N

8. Do you drink alcohol? Y or N How many drinks per week?_____

9. Do you have a stressful lifestyle? Y or N Is your body easily effected by stress? Y or N

10. Are you a positive or optimistic person? Y or N

11. How often do you exercise?_____What type of exercise?_____

12. How much sleep do you get a night?_____Do you pay attention to your diet? Y or N

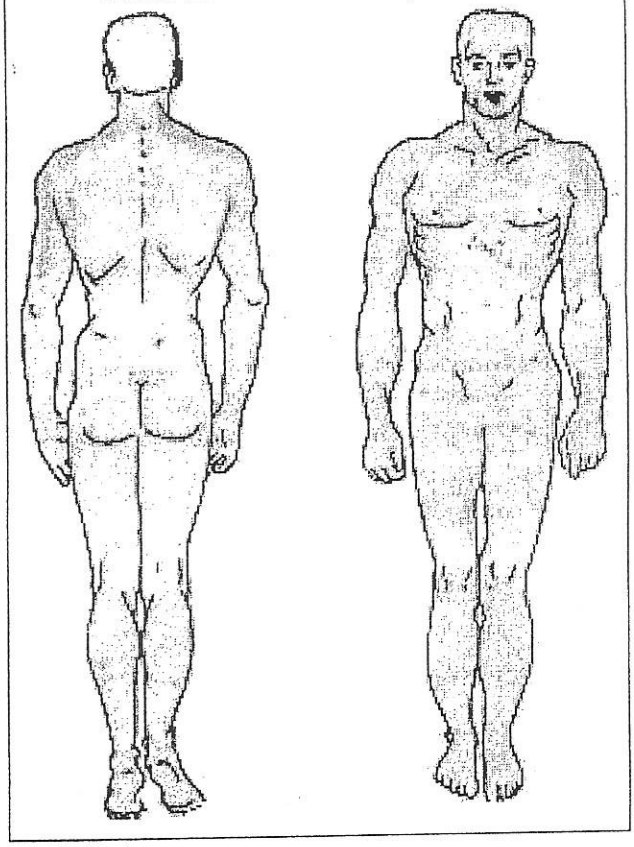
13. Would you consider your diet: a) extremely healthy b) moderately healthy c) average d) poor (circle one)

14. Do you practice preventative health care? Ex. Oral hygiene, well physical check-ups? Y or N

Please Fill in Below If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	☐	☐
Migraines	☐	☐
Neck Pain	☐	☐
Shoulder Pain	☐	☐
Arm/Hand Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Hip Pain	☐	☐
Leg/Foot Pain	☐	☐
Disc Problems	☐	☐
Arthritis	☐	☐
Other joint pain	☐	☐
Numbness	☐	☐
Joint Swelling	☐	☐
Dizziness	☐	☐
Nausea	☐	☐
Weakness	☐	☐
Fatigue	☐	☐
Nervousness	☐	☐
Insomnia	☐	☐
Heart Problems	☐	☐
Frequent colds	☐	☐
Nose Bleeds	☐	☐
Ringing in Ears	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Cough	☐	☐
Chest pains	☐	☐
Female problems	☐	☐
Allergies	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Digestive problem	☐	☐
Urinary Problems	☐	☐
Skin conditions	☐	☐
Other _____	☐	☐

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____