SPINE AND REHABILITATION CENTER OF MORRIS, LLC
210 Malapardis Road, Suite 203
Cedar Knolls, NJ 07927
Phone: (973) 359-4400
Fax: (973) 359-4414

BASIC PATIENT INFORMATION

Name: _____ **Date of birth**: _____/_____/_____

Address: _____ **City**: _____ **State**:_____ **Zip code**:_____

Home#:_____-_____-_____ **Cell#**:_____-_____-_____ **SSN#**:_____-_____-_____

Age: ____ **Birth Sex**: Male / Female **Race**: White/Black African American/Asian/American Indian Alaska Native/Hawaiian Pacific Islander/Decline **Ethnicity**: Latino / Not Latino / Decline

Preferred Language/s: _____,_____ **Marital Status**: M S D W

Email:_____ **Occupation**:_____ **Employer**:_____

Employer Address: _____ **Phone#**: _____-_____-_____

Spouse: _____ **Employer**: _____ **Occupation**:_____

Emergency Contact: _____ **Phone#**:_____-_____-_____

Please circle which type of coverage that is applicable in this case:

Major Medical Insurance / Medicare / Worker's Comp / Auto Insurance / None

Primary Insurance name: _____ **Secondary Insurance name**: _____

How did you hear about our office? :_____

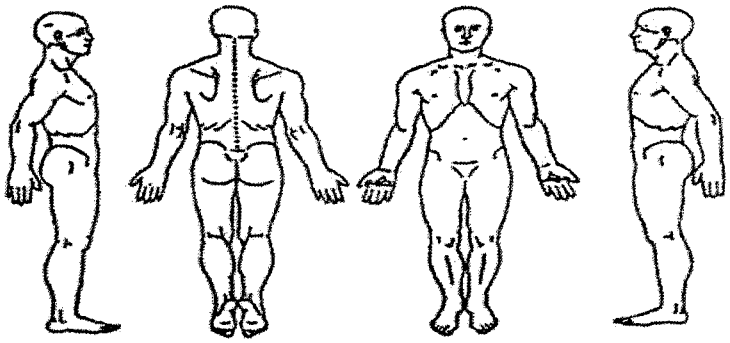
Patient Signature: _____ **Date**: _____/_____/_____

PATIENT INTAKE FORM

Patient Name: _____ Date: ____/____/____

Date of birth: ____/____/____ Height: ____'____" Weight: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation
2. Indicate on the drawings below where you have pain/symptoms:



3. How often do you experience your symptoms?
   - ☐ Constantly (76-100% of the time)
   - ☐ Frequently (51-75% of the time)
   - ☐ Intermittently (1-25% of the time)
   - ☐ Occasionally (26-50% of the time)
4. How would you describe the type of pain?

☐ Sharp	☐ Numb
☐ Dull	☐ Tingly
☐ Diffuse	☐ Sharp with motion
☐ Achy	☐ Shooting with motion
☐ Burning	☐ Stabbing with motion
☐ Shooting	☐ Electric like with motion
☐ Stiff	☐ Other: _____

5. How are your symptoms changing with time?
   - ☐ Getting worse
   - ☐ Staying the same
   - ☐ Getting better
6. Using a scale of 0-10 (10 being the worst), how would you rate your problem? (Please circle)

   0 1 2 3 4 5 6 7 8 9 10
7. How much has the problem interfered with your work?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
8. How much has the problem interfered with your social activities?

   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
9. Who else have you seen for your problem?

☐ Chiropractor	☐ Neurologist	☐ Primary care physician
☐ ER physician	☐ Orthopedic	☐ No one
☐ Massage therapist	☐ Physical therapist	☐ Other: _____

10. How long have you had this problem? _____
11. How do you think your problem began? _____
12. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No
13. What makes this problem better? _____
14. What aggravates your problem? _____
15. What concerns you the most about your problem; what does it prevent you from doing?

Occupation: _____

16. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper back Pain	☐	☐	Chest Pain	☐	☐	Frequent Urination
☐	☐	Mid back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco
☐	☐	Low back Pain	☐	☐	Angina	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systematic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	HIV/AIDS
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Other: _____
☐	☐	Knee Pain	☐	☐	Abnormal Weight Loss			
☐	☐	Ankle/Foot Pain	☐	☐	Ulcers			**For Females Only:**
☐	☐	Jaw Pain	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Joint Pain/Stiffness	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Birth Control Pills
☐	☐	Arthritis	☐	☐	General Ffatigue	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis	☐	☐	Muscular Incoordination			
☐	☐	Cancer	☐	☐	Visual Disturbances			
☐	☐	Tumor	☐	☐	Dizziness			
☐	☐	Asthma	☐	☐	Chronic Sinusitis			
☐	☐	Drug/Alcohol Dependency						

20. List all prescription medications you are currently taking:

_____

21. List all over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

☐ Sit:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day
☐ Stand:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day
☐ Computer work:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little bit of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ☐ No ☐ Yes If yes, why? _____

26. Have you had significant past trauma? ☐ No ☐ Yes If yes, what? _____

27. Anything else pertinent to your visit today? _____

Patient Signature: _____ **Date:** ____/____/____

_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

coring: Questions are scored on a vertical scale of 0-5. Total scores
ıd multiply by 2. Divide by number of sections answered multiplied by
). A score of 22% or more is considered a significant activities of daily
ing disability.
core___ x 2) / (___Sections x 10) = _____ %ADL_____

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

coring: Questions are scored on a vertical scale of 0-5. Total scores nd multiply by 2. Divide by number of sections answered multiplied by). A score of 22% or more is considered significant activities of daily ing disability.
icore___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

PATIENT OFFICE AGREEMENT

INSURANCE:
As a courtesy to our patients, we will verify your benefits and file insurance claims on your behalf to the carrier(s) that you have provided our office. However, if your insurance changes or terminates throughout your care, we ask that as a courtesy you provide us with updated and current information as soon as possible.

INSURANCE PAID TO PATIENT (BCBS PT's only):
As a non-participating provider, Horizon Blue Cross & Blue Shield will send the insurance payments directly to you in the name of insured or subscriber. You understand that it is your responsibility to endorse or remit your payment within 14 calendar days.

FINANCIAL RESPONSIBILITY:
Patient deductibles, co-insurances and/or the agreed office payment(s) are due prior to services being received. For your convenience we accept cash, personal check, Visa, MasterCard and Discover as forms of payment.

Returned check(s) fee is $30.00

AUTO ACCIDENT PATIENTS:
Patients who have elected to not use their health insurance to serve as their secondary coverage, will be responsible for the 20% Co-Pay for each visit in addition to the selected plan's deductible. Should you be represented by an attorney, the financials responsibility will come out of the case's settlement, if any. If for any reason, the case is dropped by the representing attorney or there is no settlement, the patient is fully responsible for the plan's deductible and 20% Co-Payment.

LEGAL FEES:
I understand and agree that should it become necessary for my account to be sent out to a third party collection, such as an attorney or agency for collection or suit, I will be responsible to pay for all reasonable attorney fees and collection costs.

SUPPLIES AND EQUIPEMENT:
I understand and agree that should my insurance company not cover the provided supply(s) or equipment, I am responsible to pay for the supply and/or return the supply(s) or equipment within 7 days of being advised of the same. Should I fail to do the same, I will be financially responsible.

ASSIGNMENT OF INSURNACE BENEFITS:
I understand that I will be assigning my medical benefits to this clinic. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Spine and Rehabilitation Center of Morris LLC, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by the insurance(s).

AUTHORIZATION FOR TREATMENT:
I hereby authorize and consent to the administration of any medical, diagnostic or therapeutic treatment, as may be deemed medically necessary or advisable. I have the right to refuse consent, to any proposed procedure or therapeutic course. 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.

CERTIFICATION:
I hereby certify that I have read each of the above statements, have had each explained to me to my satisfaction, and have been offered a copy of this patient agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this patient agreement. A photocopy of this document has the same effect has an original.

PATIENT SIGNATURE	RELATIONSHIP TO PATIENT	DATE SIGNED
PATIENT NAME-PLEASE PRINT	WITNESS SIGNATURE	DATE SIGNED

SPINE AND REHABILITATION CENTER OF MORRIS, LLC
210 MALAPARDIS ROAD, SUITE 203
CEDAR KNOLLS, NJ 07927
PHONE: (973) 359-4400
FAX: (973) 359-4414

OFFICE POLICY REGARDING INSURANCE CHECKS

Dear Patients:

This letter is to inform you that you may be directly receiving checks from your insurance carrier for the treatments that you have received in our office. It is your responsibility that you forward these checks and any correspondence that is included into our office. In the event that you withhold and cash the checks you are ultimately responsible for the amount, as well as any balance of your account.

By signing this letter you agree and acknowledge to all terms stated above.

_____
Print Name

_____
Signature

_____
Date

Malapardis Road, Suite 205
Cedar Knolls, NJ 07927

HIPAA HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any healthcare operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made to submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent needs to only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment or health care operations, the physicians and therapists have the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date