280 US Highway 9, Morganville, NJ 07751
www.GetWellNJ.com
(732) 617-9355

Upper Cervical Chiropractic of Monmouth, LLC

Confidential Health Record

Welcome To Our Office! Today's Date M/D/Y ___/___/___

Whom may we thank for referring you to our office? _____

Personal Information

Name LAST _____ FIRST _____ MIDDLE _____

Birth Date M/D/Y ___/___/___ Age _____ Sex PLEASE CHECK ○ Male ○ Female

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone # HOME _____ CELL _____ WORK _____

Email Address _____ Occupation _____

Marital Status PLEASE CHECK ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated

Spouses Name LAST _____ FIRST _____ # of Children _____

Insurance Carrier _____

Why Upper Cervical Chiropractic?

Most people go to Chiropractors for either symptomatic relief of a problem (RELIEF CARE) or for treating the cause of the problem in addition to relief of their symptoms (CORRECTIVE CARE). Your doctor will weigh your needs and desires when recommending your program of care. PLEASE CHECK THE TYPE OF CARE YOU NEED:

Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak. ○

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective Care varies in length of time, but is more lasting. ○

Emergency Contact

Name LAST _____ FIRST _____ Relationship ○ Spouse ○ Relative ○ Friend

Phone # HOME _____ CELL _____ WORK _____

Present Health Challenge

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR **CHIROPRACTIC WELLNESS SERVICES**, CHECK HERE ○

Unwanted Health Challenge

Explain why you are here today _____

_____

_____

_____

_____

Has it ever occurred before? ○ Yes ○ No

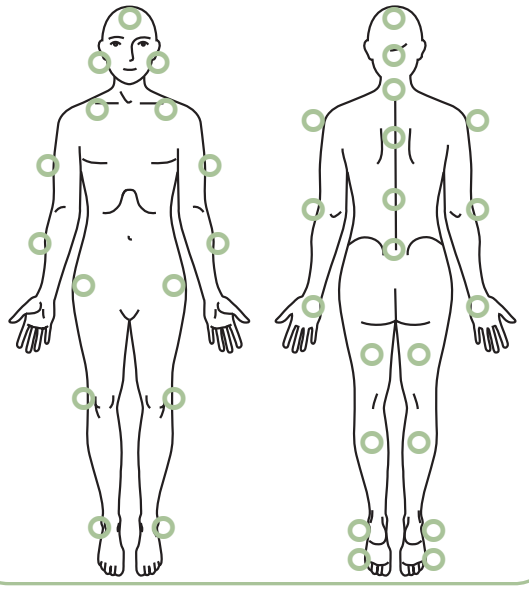
When do you think these problems originally started? _____

_____

_____

Date of Auto Crash or Work Related Injury M/D/Y ___/___/___

PLEASE CHECK ON THE DIAGRAM THE AREA OF DISCOMFORT



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PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE BLANKS.

Body Area(s) Involved ○ Neck ○ Back ○ Head ○ Other _____

Mechanism of Onset ○ Auto ○ Work ○ Slip/Fall ○ Other _____ Onset Date M/D/Y ___/___/___

Current Symptoms ○ Pain ○ Numbness ○ Stiffness ○ Weakness ○ Other _____

Quality ○ Burning ○ Diffuse ○ Dull/Aching ○ Localized ○ Radiating ○ Sharp ○ Shooting
○ Stabbing ○ Throbbing ○ Tightness ○ Tingling ○ Other _____

Timing ○ Morning ○ Afternoon ○ Night ○ With Activity ○ Constant ○ Intermittent

What Makes it Worse? _____

What Makes it Better? _____

Level of Impairment Due to Symptoms CHECK THE APPROPRIATE LEVEL WITH **0 = NONE / 10 = EXTREME**

While Resting	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
With Activity	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

Headaches

Location	○ Occipital	○ Frontal	○ Left Temporal	○ Right Temporal	○ Parietal	○ Sinus
Quality	○ Dull	○ Sharp	○ Throbbing	○ Stabbing	○ Aura	○ No Aura
Types	○ Hat Band	○ Cluster	○ Migraine	○ Tension		

Employment – Occupation/Job Title _____ Work # _____ hours per day

Conditions Effect on Job Performance ○ No Effect ○ Mild Pain ○ Moderate Pain ○ Unable to Perform

Daily Activities – Effects of Current Condition on Performance

Bending	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Change Position (Sit-Stand)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Climb Stairs	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Driving	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Extended Computer Use	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Household Chores / Yard Work	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Lifting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Reading/Concentration	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Self Care (Bathe/Dress)	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Sleep	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Sitting	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Prolonged Standing	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)
Walking	○ No Effect	○ Mild (Can do)	○ Moderate (Limited)	○ Severe (Unable to Perform)

Recreational Activities – PLEASE LIST ANY CURRENT RECREATIONAL ACTIVITIES AND CHECK THE EFFECTS OF CURRENT CONDITION ON PERFORMANCE

_____ ○ No Effect ○ Mild (Can do) ○ Moderate (Limited) ○ Severe (Unable to Perform)

LIFESTYLE REVIEW

1. On a scale of Poor, Good, Excellent please describe your lifestyle MARK **POOR**, **GOOD** OR **EXCELLENT**.

   Diet _____ Exercise _____ Sleep _____ General Health _____

2. What Wellness services/products do you currently incorporate into your lifestyle? _____

3. What Supplements are you currently taking? _____

4. On a scale of 1-10 describe your stress level **1 = NONE / 10 = EXTREME** Occupational _____ Personal _____

5. **What are your top two health goals? 1.** _____ **2.** _____ **or ○ I do not have any**

6. **Are you pregnant?** ○ Yes ○ No

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Review of Systems

PLEASE CHECK THE ITEMS BELOW THAT APPLY TO YOU.

Nervous System

- ○ Dizziness ○ Seizures ○ Loss of Memory ○ Slurred Speech ○ Loss of Consciousness
- ○ Strokes ○ Tremor ○ Limb Weakness ○ Fatigue ○ Sleep Disturbance
- ○ Stress ○ Numbness ○ Headache ○ Loss of Balance ○ Tinnitus/Ringing in Ears

Respiration

- ○ Asthma ○ Cough ○ Wheezing ○ Sputum Production ○ Shortness of Breath

Cardiovascular

- ○ I DENY Any Symptoms ○ Chest Pain ○ Swelling Of Legs ○ Low Blood Pressure ○ Claudication (Leg Pain/Ache)
- ○ Palpitations ○ Varicose Veins ○ High Blood Pressure ○ Shortness Of Breath

Gastrointestinal

- ○ Diarrhea ○ Indigestion ○ Abnormal Stool ○ Vomiting Blood ○ Weight Changes
- ○ Belching ○ Vomiting ○ Abdominal Pain ○ Constipation ○ Difficulty Swallowing
- ○ Nausea ○ Heartburn ○ Ulcers

Psychologic

- ○ Irritability ○ Insomnia ○ Memory Loss ○ Behavioral Change ○ Bi-Polar Disorder
- ○ Anxiety ○ Depression ○ Mood Change ○ Loss or Change in Appetite

Immune

- ○ Itching ○ Anaphalaxis ○ Food Intolerance ○ Nasal Congestion ○ Rash

Health History

FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

Previous Chiropractic Care: ○ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name _____ Date of Last Visit M/D/Y ___/___/___

Current Medication(s) LIST **ANY/ALL** MEDICATIONS YOU ARE **CURRENTLY** TAKING. BE SPECIFIC. _____

_____

Doctor's Name _____

Illness(es) **LIST** ALL HEALTH CONDITIONS. _____

_____

Surgery(ies) **LIST** ALL SURGICAL PROCEDURES. WRITE THE **DATE** OF THE PROCEDURE IMMEDIATELY AFTERWARD. _____

_____

Injury(ies) MARK OR LIST ALL INJURIES. WRITE THE **DATE** OF THE INJURY IMMEDIATELY AFTERWARD.

- ○ Fall (Severe) M/D/Y ___/___/___ ○ Broken Bones M/D/Y ___/___/___ ○ Loss of Consciousness M/D/Y ___/___/___
- ○ Head Injury M/D/Y ___/___/___ ○ Back/Neck Injury M/D/Y ___/___/___ ○ Motor Vehicular Crash M/D/Y ___/___/___

Social History

Tobacco ○ Do not use tobacco ○ Smoke/Chew: # _____ per Day ○ Live with a smoker ○ Quit smoking

Alcohol ● Do not use alcohol ○ # _____ Drinks per Week ○ # _____ Drinks per Month

An evaluation will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays).

The statements made on this form are accurate to the best of my recollection and I knowingly allow UCC of Monmouth to examine me for further evaluation/treatment, and understand that I am responsible for all charges incurred.

Signature _____ **Date** M/D/Y ___/___/___

Thank you for allowing us to serve you!