Center Street Chiropractic • 552 Main Street Chatham, NJ 07928 • 973-635-3100

Registration and Patient History

Date: ______________________ Patient SS # ______________________

Name: ______________________ Date of birth: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ________

Phone: (H) ______________ (C) ______________ Carrier ____________ Text message reminder Y/N

Email: ______________________ Occupation ______________________

Emergency contact: Name ______________ Phone: ______________ Relationship: ___________

□ Married □ Widowed □ Single □ Divorced □ Separated □ Minor □ Partnered

Who referred you to our office? ______________________

Reason for visit:

____

When did this condition begin? ______________________

Is the condition getting progressively worse □ Yes □ No

Rate your severity of pain: Mild 1 2 3 4 Moderate 5 6 7 8 Severe 9 10 10+ (circle)

How often do you have this pain? Less than _____25% ______25% ______50% ______75% ______100% of the day.

Is your condition worse: upon waking /morning/afternoon/evening/positional/during sleep/

as the day progresses/all the time?

Do your symptoms radiate/refer to any other part of the body? ______________________

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down

Does this condition interfere with your: daily routine / exercise / sleep / sports / work / other __________

Type of pain □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other ______________________

What helps your condition? ______________________

What aggravates your condition? ______________________

What treatments have you already received for your condition? □ Medications □ Surgery □ Physical Therapy

□ Chiropractic Services □ None □ Other ____________ Where ______________ When __________

What are your goals for chiropractic care? □ pain/symptom relief □ corrective care □ supportive care

Date of last physical exam: ______________ Name of primary care physician: ______________

Do you exercise regularly? ______________________

List any medically diagnosed conditions: ______________________

Are you pregnant? ______________________

List any allergies: ___

List all medications you take: ___

List all vitamins, herbs, or homeopathic remedies you take: ___

List all hospitalizations and/or surgical procedures: ___

List any falls, accidents, or injuries ___

Have you ever had any of the following conditions (please circle ALL that apply) : ADD/ADHD, Allergies, Anxiety, Arthritis, Asthma, Back Pain, Blood Pressure Disorders, Cancer, Concussion, Depression, Diabetes, Dizziness, Ear Infections, Fractures, Headaches, Heart Problems, Herpes, Hepatitis (A,B,C), HIV, Learning Disabilities, Neck Pain, Nervousness, Sciatica, Scoliosis, Seizures, Sinus Problems, Vertigo, Weight issues, Other:

___

Is there anything else I should know about you or your child's health? ___

___

Is condition due to an accident? ☐ Yes ☐ No DATE ___

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other ___

In order to comply with federal regulations, we are required to ask you to provide the following information:

Race:☐ White/Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other ☐ I prefer not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Unreported

Have you ever been diagnosed with: ☐ Hypertension YES/NO ☐ Diabetes YES/NO

Smoking Status: ☐ Never Smoked ☐ Current Smoker ☐ Former Smoker

Primary Language: ☐ English ☐ Spanish ☐ Other ___

FAMILY HISTORY

	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRAND PARENTS	PATERNAL GRAND PARENTS
CANCER						
DIABETES						
HIGH BLOOD PRESSURE						
HEART DISEASE						
HEART FAILURE						
KIDNEY DISEASE						
STROKE						
LIVING						
DECEASED						

INSURANCE INFORMATION

Insurance Company: ___________________ ID# ________________________________ GROUP# ______________

Subscriber's Name ____ Date of birth ___________________________

Relationship to the patient: ____

Who is responsible for this account: ____

CONSENT FOR PROFESSIONAL SERVICES AND CONSENT FOR NUTRITIONAL COUNSELING

I hereby authorize the doctor to administer chiropractic examination, chiropractic care, treatment, order x-rays or imaging studies or any other services that he deems necessary in my or my child's case.

During the course of your treatment Dr. Drumbore may provide nutritional guidance. This is provided to you in order to support your body, improve your overall health, or speed the healing process. The advice given is general in nature and is not intended to treat a specific disease or symptom.

Dr. Drumbore may recommend specific nutritional supplements. Nutritional supplements have been proven to be safe when taken as directed, yet there is a chance for an adverse reaction from any product. If you feel you are having a reaction to a recommended nutritional supplement, stop using the product until you can discuss the matter with Dr. Drumbore.

All medication changes need to be made by your medical physician (M.D.)

Patient's signature ____ **Date** ____________________

Patient or guardian signature ____ **Date** ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Center Street Chiropractic, LLC's Notice of Privacy Practices for protected health information.

Name of Patient: ____ (please print)

Signature of Patient/Personal Representative ____

DATE ____

Neck Pain and Disability Index (Vernon-Minor)

Patient Name:________________________________ **Date:** ________________ **Score**: ________

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **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 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 weight but it causes extra pain.
□ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g.: on the 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 a slight pain in my neck.
□ I can read as much as I want to with moderate pain in my neck.
□ I can't read as much as I want to 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 moderate headaches which come infrequently.
□I have moderate headaches which come frequently.
□I have severe headaches which come frequently.
□I have headaches almost all the time.

Please flip over and complete the second part of questionnaire

- **Section 6-CONCENTRATION**

□ I can concentrate fully when I want 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 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 can drive my car without any neck pain.
□I can drive my car as long as I want with slight neck pain.
□I can drive my car as long as I want with moderate neck pain.
□I can't drive my car as long as I want because of moderate neck pain
□I can hardly drive 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 mildly disturbed (1-2 hrs. sleepless)
□My sleep is moderately disturbed (2-3hrs. sleepless)
□My sleep is greatly disturbed (3-5 hrs. sleepless)
□My sleep is completely disturbed (5-7 hrs. sleepless)

- Section 10-**RECREATION**

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

- **Pain Severity Scale**:
  Rate the severity of your pain by circling one of the numbers on the following scale:

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Excruciating Pain**

Low Back Pain and Disability Questionnaire (Revised Oswetry)

Patient Name:_________________________ **Date:** ______________ **Score**:________

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **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**

□The pain comes and goes and is very mild.
□The pain is mild and does not vary much.
□The pain comes and goes and is moderate.
□The pain is moderate and does not vary much.
□The pain comes and goes and is severe.
□The pain is severe and does not vary much.

➢ Section 2- **PERSONAL CARE**

□ I would not have to change my way of washing or dressing in order to avoid pain.
□I do not normally change my way of washing or dressing even though it causes some pain.
□Washing and dressing increase the pain but I manage not to change my way of doing it.
□Washing and dressing increase the pain and I find it necessary to change my way of doing it.
□ Because of the pain I am unable to do some washing and dressing without help.
□Because of the pain I am unable to do any washing and dressing without help.

➢ Section 3-**LIFTING**

□ I can lift heavy weights without extra pain.
□ I can lift heavy weight but it causes extra pain.
□ Pain prevents me from lifting heavy weights off the floor
□ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g.: on the table).
□Pain prevents me from lifting heavy weight but I can manage light to medium weights if they are conveniently positioned.
□I can only lift very light weights at the most.

➢ Section 4-**WALKING**

□ I have no pain while walking.
□ I have some pain while walking but it does not increase with distance.
□I cannot walk more than one mile without increasing pain.
□I cannot walk more than ½ of a mile without increasing pain.
□I cannot walk more than ¼ of a mile without increasing pain.
□I cannot walk at all without increasing pain.

➢ 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 a half hour.
□Pain prevents me from sitting more than 10 minutes.
□I avoid sitting because it increases pain straight away.

Please flip over and complete the second part of questionnaire

➢ **Section 6-STANDING**
□ I can stand as long as I want without pain.
□I have some pain on standing but it does not increase with time.
□I cannot stand for longer than one hour without increasing pain.
□I cannot stand for longer that a ½ hour without increasing pain.
□I cannot stand for longer than 10 minutes without increasing pain.
□I avoid standing because it increases the pain straight away.

➢ Section 7-**SLEEPING**
□I get no pain in bed.
□I get pain in bed but it does not prevent me from sleeping well.
□Because of pain my normal night's sleep is reduced by ¼.
□ Because of pain my normal night's sleep is reduced by ½.
□ Because of pain my normal night's sleep is reduced by ¾.
□ Pain prevents me from sleeping at all.

➢ Section 8- **SOCIAL LIFE**
□My social life is normal and gives me no 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 interest, e.g. dancing etc.
□Pain has restricted my social life and I do not go out often.
□Pain has restricted my social life to my home.
□I hardly have any social life because of the pain.

➢ Section 9- **TRAVELLING**
□I get no pain while travelling.
□I get some pain while travelling but none of my usual forms of travel make it any worse.
□I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
□I get extra pain while travelling which compels me to seek alternative forms of travel.
□Pain restricts all forms of travel.
□Pain prevents all forms of travel except that done lying down.

➢ 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 improvements is slow at present.
□My pain is neither getting better or worse.
□My pain is gradually worsening.
□My pain is rapidly worsening.

➢ **Pain Severity Scale**:
Rate the severity of your pain by circling one of the numbers on the following scale:

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Patient Financial Policy

Dr. Kevin Drumbore
Center Street Chiropractic • 552 Main Street • Chatham, NJ 07928
973-635-3100

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. You are responsible for your deductibles, coinsurance and co-pays. Payment is due at the time of services are rendered. We are non-participating with all insurance plans. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Canceling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

FEE SCHEDULE

Service	Fee	
New Patient Examination	$ 300.00	
Re-Exam	$ 35.00	
Spinal Adjustment	$ 80.00	
Medicare Spinal Adjustment:		
1 -2 Regions	$ 33.73	
3- 4 Regions	$ 48.32	
5 Regions	$ 62.49	
Extremity Adjustment	$ 25.00	
Electro -Therapy	$ 30.00	
Maintenance Adjustment (non-reimbursable by insurance)	$ 70.00	w/electro-therapy $ 90.00

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

Patient Name, (Printed) ______________________ Witness: ______________________

Signature ______________________ Date ______________________