Terry Wulster, D.C.
Denville Community Chiropractic Center

35 W. Main Street, Suite 100
Denville, NJ 07834
Office: 973.625.2600
Fax: 973.625.2650

Chiropractic healthcare and wellness are possible only when the practitioner completely understands the patients' physical, mental, and emotional status. The information you provide helps us understand your needs and how to better help you reach your health goals. Please write legibly and answer all questions completely. Ask the office staff if you have any questions.

Patient Intake Form

Today's Date: _____ Email: _____

Name: _____
First Last

Street Address: _____ Apt #:_____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____ Other: _____

SS#: _____ Birth Date: _____ Age: _____ Gender (circle) M F

- Preferred # for contacting you and for appointment reminders: ☐ Home ☐ Work ☐ Cell ☐ Other
- Is it OK to receive mail at your home from our clinic? ☐ Yes ☐ No
- Would you like to receive periodic newsletters via e-mail? ☐ Yes ☐ No
- What is your email address? _____

Race/ Ethnicity (circle): Caucasian African American Hispanic Asian Other: _____

Emergency Contact: _____ **Phone Number:** _____

HIPAA authorization to discuss your health with: ☐ Spouse ☐ Child ☐ Sibling Other: _____

Employer: _____

Work Address: _____

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Retired

Marital Status (circle): S M D Other: _____ # of children: _____

Insurance Company: _____

ID #:_____ Group #:_____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to Insured: _____

How did you hear about our clinic? ☐ Website ☐ Advertisement ☐ Friend/Family ☐ Other:_____

Current Health Condition

Reason for your office visit today:

_____

_____

Date when symptoms first started: _____

Did the problem begin: ☐ Gradual ☐ Sudden ☐ Progressive (over time)

What makes your pain worse? _____

What relieves your pain? _____

Describe the pain: ☐Sharp ☐Dull ☐Burning ☐Achy ☐Tight ☐Stiff ☐Throbbing ☐Stabbing ☐Electrical

Does pain radiate down your: ☐Arms ☐Hands ☐Legs ☐Feet ☐Does not radiate ☐Left Side ☐Right Side

Rate your pain on a scale of 0 to 10 (0= No Pain, 10= Extreme Pain): _____

Are you experiencing Numbness and Tingling? ☐Yes ☐No Where: _____

What percentage of your day are you in pain? ☐10% ☐25% ☐50% ☐75% ☐90% ☐100%

Are you currently being treated by another doctor or specialist for this current problem? ☐Yes ☐No

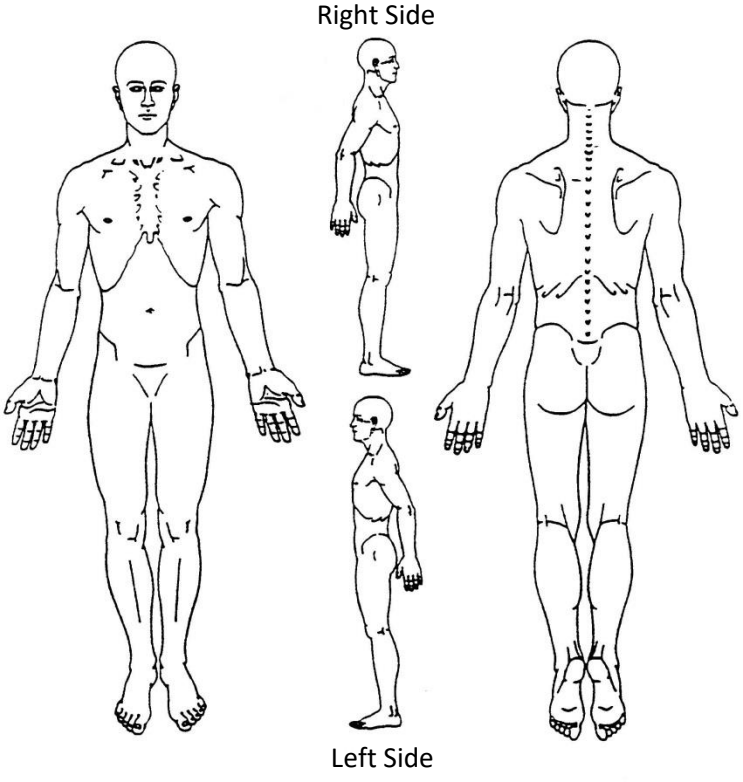
If yes, please explain: _____

_____

When and where did you last receive medical care and for what reason? _____

_____

Who is your Primary Care Doctor? _____



Please mark the areas of your complaints on the diagram using the following indicators:

X = Pain

O = Numbness

Z = Tingling

B = Burning

T = Tightness

S = Sharp

R = Scar

PAST MEDICAL HISTORY

Please check if you have or had any of the following:

☐ AIDS/HIV	☐ Cancer	☐ Gout	☐ Malaria	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Cataracts	☐ Heart Attack	☐ Migraines	☐ Strokes/TIA
☐ Anemia	☐ Chemical Dependency	☐ Heart Disease	☐ Miscarriage	☐ Thyroid Problems
☐ Allergy Shots	☐ Diabetes	☐ Hepatitis	☐ Multiple Sclerosis	☐ Tick Born Illness
☐ Anorexia	☐ Disc Herniation	☐ Hernia	☐ Osteoporosis	☐ Tuberculosis
☐ Arthritis	☐ Emphysema	☐ Herpes	☐ Pacemaker	☐ Tumors/Growths
☐ Asthma	☐ Epilepsy	☐ High Blood Pressure	☐ Parasites	☐ Ulcers
☐ Bleeding Disorders	☐ Fatigue	☐ High Cholesterol	☐ Parkinson's	☐ Vaginal Infections
☐ Breast Lump(s)	☐ Glaucoma	☐ Kidney Disease	☐ Pinched Nerve	☐ Vascular Disease
☐ Bronchitis	☐ Goiter	☐ Liver Disease	☐ Pneumonia	☐ Venereal Disease
☐ Bulimia	☐ Gonorrhea	☐ Lyme's Disease	☐ Prostate Problem	☐ Yeast Infections

☐ Other: _____

Allergies: _____

What hospitalizations, surgeries, or injuries have you had? _____

_____

What diagnostic imaging tests have you had? ☐ X-Rays ☐ CT Scan ☐ MRI Other: _____

Please list all medications and supplements you are currently taking with dosages:

1. _____ **5.** _____
2. _____ **6.** _____
3. _____ **7.** _____
4. _____ **8.** _____

Do you have any medication allergies? (circle) No/ Yes: If yes, please state: _____
_____

Childhood Illnesses

Do you or have you had any of the following conditions? **(Please check all that apply.)**

☐ Chickenpox	☐ Whooping cough	☐ Asthma	☐ Rubella (German measles, 3 days)
☐ Diptheria	☐ Mumps	☐ Polio	☐ Measles (2 week illness)
☐ Roseola	☐ Rheumatic fever	☐ Ear infections	☐ Strep Throat
☐ Scarlet fever	☐ Mononucleosis	☐ Epilepsy	Other:_____

FAMILY HISTORY

Do you have a family history **(BLOOD RELATIVE)** of any of the following? **(Please check all that apply.)**

☐Alcoholism
☐Allergies
☐Anemia
☐Arthritis
☐Asthma
☐High Blood Pressure
☐Cataracts
☐Hayfever/Hives
☐Depression
☐Diabetes
☐Liver Disease
☐Cancer (type):_____
☐Multiple Sclerosis
☐Skin Diseases
☐Headaches/Migraines
☐Heart Disease
☐Tuberculosis
Other: _____
☐Mental Illness
☐Stroke
☐Suicide
☐Kidney Disease
☐Thyroid Condition

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____

Do you currently use tobacco? ☐Yes ☐No How long? _____ How much daily?_____

Have you ever used tobacco products in the past? ☐Yes ☐ No When did you quit? _____

Do you currently use recreational drugs? ☐Yes ☐No What kind? _____

Do you consume caffeine? ☐Yes ☐No How much daily? _____

Do you have any physical limitations or disabilities? ☐Yes ☐No Explain: _____

Do you exercise? ☐Yes ☐No What form(s)?_____

How often do you exercise? _____

Rate your stress from 0 to 10 (0=No Stress, 10= Extreme Stress): _____

Are you sexually active? ☐Yes ☐No

Height: _____ Weight: _____ lbs. Date of last physical exam: _____

Health Information Portability and Accountability Act (HIPAA) I authorize Denville Community Chiropractic Center, Dr. Terry Wulster, and/or any other covering provider and/or staff member to act on my behalf in regards to claims processing or payment activities as it relates to services rendered in this office. I also authorize the use of my name as it relates to Recalls, Newsletters, Mailings and/or Patient Referral Board. I also authorize any messages relating to the above to be left on voicemail or e-mail address provided below. I acknowledge, accept and agree to allow this chiropractor office to use my health information for the purpose of treatment, payment, healthcare operations and coordination of care with other healthcare professionals and insurance companies. I understand that a more detailed version of the HIPAA NOTICE that explains the policy and procedures concerning the privacy of my health information is available at the front desk for me to review at any time.

Phone number to leave messages: _____

E-mail Address: _____

Patient Signature: _____ Date: _____

Patient Authorization of Records Release

To: Denville Community Chiropractic Center
35 W. Main St., Suite 100 Denville, NJ 07834
Telephone: 973-625-2600 / Fax: 973-625-2650

I hereby authorize Dr. Wulster and/or any covering chiropractic physician and staff member at Denville Community Chiropractic Center to obtain or forward any medical information pertinent to any diagnosis and/or treatment, including insurance claims processing relating to myself. I hereby authorize Dr. Wulster and/or any covering doctors at Denville Community Chiropractic Center to obtain radiographs, medical records, and/or any other medical information pertinent to any diagnosis and treatment relating to myself (or my child).

Patient's Name (Print) _____
Patient's Signature/ Parent or Guardian _____
Date: _____

ASSIGNMENT OF BENEFITS TO OUR OFFICE

Please Note: Your health insurance and/or automobile insurance is a contract between YOU and YOUR INSURANCE CARRIER! Please contact your insurance company with any questions or concerns regarding your benefits/coverage. YOU are responsible to pay any deductibles, co-payments or co-insurance fees required at the time services are rendered. By signing below you acknowledge, accept and agree to this notice.

I hereby request my insurance company, _____ to make DIRECT PAYMENTS to Dr. Terry Wulster at Denville Community Chiropractic located at 35 W. Main St., Suite 100 Denville, NJ 07834.

I authorize the reimbursement from my insurance company to Dr. Terry Wulster and/or any covering doctor at Denville Community Chiropractic Center based on any benefits due me under a contract that I have with my health (medical) insurance company, automobile (personal injury) insurance company, based on its own policies and guidelines, may make determinations of medical necessity different from the doctors practicing at Denville Community Chiropractic Center. I acknowledge, accept and agree to be personally responsible for the payment of any services rendered to me (or my child) by Dr. Terry Wulster at Denville Community Chiropractic Center that are not reimbursed by my insurance company. I authorize Dr. Terry Wulster to release any information pertinent to my care at Denville Community Chiropractic Center to my insurance company, utilization company or attorney that may request my records.

Patient's Name (Print) _____
Patient's Signature/ Parent or Guardian _____
Date: _____

Credit Card Authorization

It is our office policy, that if we are submitting claims on your behalf, that you provide us with credit card information in the event that your insurance company does not pay for services rendered within 180 days.
I authorize the billing of services rendered for chiropractic care by Dr. Terry Wulster and/or any other covering provider in our office.

Credit Card #: _____ Exp. _____

Name on card: _____

Authorized Signature: _____ Date: _____ CVV: _____

Informed Consent for Examination & Treatment

By signing below I hereby authorize and consent to the services rendered and provided to me (or my child) as necessary to facilitate my diagnosis and treatment under the instructions of the chiropractors practicing at 35 W. Main St. Ste. 100, Denville, NJ 07834. I do hereby give my consent for the performance of conservative noninvasive chiropractic treatment to the joints and soft tissue of my body. I understand that the procedures may consist of joint manipulation, known as the adjustment, and muscle stretching involving the movement of my joints and soft tissues. I understand, acknowledge and accept that the adjustment may be given to me by the use of the chiropractors' hands placed upon my body or by the use of a mechanical adjusting instrument in such a way as to move my joints. I acknowledge that this joint movement may cause an audible "pop" or "click," and I may feel a sense of movement.

As part of the analysis, examination and treatment, I am voluntarily consenting to chiropractic adjustments. I also consent to a physical examination of my body, manual palpation, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, muscle stretching, postural analysis, therapeutic ultrasound, hot and cold application therapies, electrical muscle stimulation, the use of massage creams or gels for muscle pain and spasm, massage by mechanical device, cold laser therapy and lifestyle modifications as part of my care.

Although chiropractic adjustments are considered to be one of the safest, most efficient forms of therapy for neurological and musculoskeletal conditions, I am aware of the benefits and understand, acknowledge and accept that there are possible risks and complications associated with these procedures. Potential benefits include but are not limited to decreased pain, improved joint mobility and function, reduced muscle hypertonicity, assistance in injury recovery and possible prevention of musculoskeletal disease or its progression. Potential risks include but are not limited to muscle strain, cervical myelopathy, costovertebral sprain and separations, burns, fractures, disc injuries and dislocations, stiffness and soreness following the adjustment, dizziness, nausea, and localized allergic skin reactions from the use of topical creams or gels or from the electrical stimulation pads.

I acknowledge, accept and agree that other treatment options for my condition may include but are not limited to self-administered, over-the-counter analgesics and rest, allopathic medical care and prescription drugs such as anti-inflammatory medications, muscle relaxants, prescription pain relievers, hospitalization and/or surgery. If I choose to use any one or combination of the above noted "other treatment" options, I acknowledge that there are inherent risks of such options and that I will discuss these with my primary care physician.

With this knowledge, I voluntarily consent to the above treatment options, realizing that no guarantees have been given to me by my doctor regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have discussed my questions or concerns with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks and benefits involved in undergoing treatment and have voluntarily decided that it is in my best interest to undergo the treatment recommended. This is my freedom of choice for my healthcare. I have stated all medical conditions that I am aware of and will keep my doctor informed of any changes to my health and further acknowledge that the doctors will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant or trying to get pregnant as soon of the therapies used could present a risk to a pregnancy.

Patient's Name (Print): _____

Patient's Signature/ Parent or Guardian: _____

Date: _____