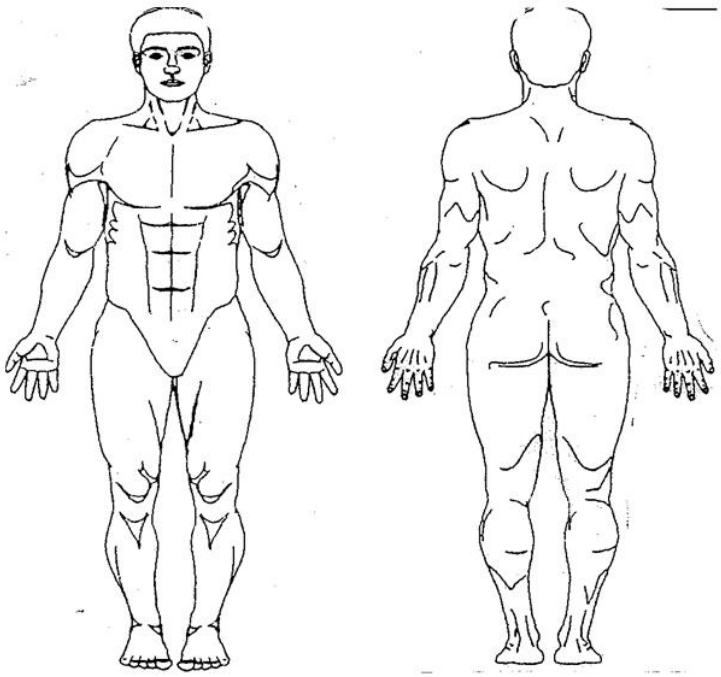
PATIENT INTAKE FORM

Please check the type of care desired: ☐ Temporary Relief ☐ Lasting Correction
☐ Check here if you want the Doctor to recommend the best type of care for you.
I would like to start: ☐ *Acupuncture treatments* ☐ *Chiropractic treatments* Today's Date:_____
Name:_____ Date of Birth: _____
Address:_____City:_____State_____Zip Code_____
Home Phone Number:_____ Phone at work:_____ ext._____
Height_____Weight_____Age _____
Check if you are: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated
Name of Husband/Wife: _____ Ages of Children: _____
Employer of Insured:_____Address:_____
E-mail Address:_____Referredtoour officeby:_____
W ho is responsible for your bill? ☐Self ☐Spouse ☐Employer ☐Insurance ☐Other_____
How Payment will be made: Type of Insurance
_____Cash _____Credit Card _____Workers' Comp. _____Health Insurance
_____Check _____Automobile Ins. Policy

If you are in pain, please mark the exact location of your pain, on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

MAJOR COMPLAINT
(please only describe your major problem)

COMPLETE THESE DIAGRAMS



How did this condition develop?(What caused it? How did it start?)_____

When was the very first time you were aware of this problem?_____
Have you ever had this problem or similar problem before? If yes, please explain: _____

Have you ever received any treatment for this condition? If yes, where and when, and what were the results?_____

Has this problem been getting better, worse, or staying the same?_____

PLEASE COMPLETE REVERSE SIDE

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Cold Hands
- ☐ Fevers
- ☐ Cravings
- ☐ Sudden Energy drop at _____(time)
- ☐ Heavy appetite
- ☐ Fatigue
- ☐ Cold Feet
- ☐ Chills
- ☐ Localized weakness
- ☐ Peculiar tastes/smells
- ☐ Poor sleep
- ☐ Tremors
- ☐ Cold back
- ☐ Night sweats
- ☐ Poor coordination
- ☐ Change in appetite
- ☐ Heavy sleep
- ☐ Vertigo
- ☐ Cold abdomen
- ☐ Sweat easily
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Hepatitis A/B/C or other
- ☐ Bleed or bruise easily
- ☐ Lyme Disease
- ☐ Herpes
- ☐ Diabetes
- ☐ Thyroid Disease

SKIN AND HAIR

- ☐ Rashes
- ☐ Eczema
- ☐ Ulceration's
- ☐ Pimples
- ☐ Hives
- ☐ Dandruff
- ☐ Itching
- ☐ Loss of hair
- ☐ Purpura
- ☐ Other hair or skin problems

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Gum Problems
- ☐ Teeth Problems
- ☐ Other head or neck problems
- ☐ Ringing in ears
- ☐ Concussions
- ☐ Eye Pain
- ☐ Poor hearing
- ☐ Migraines
- ☐ Poor vision
- ☐ Dry throat
- ☐ Blurry vision
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Earaches
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Copious saliva
- ☐ Facial pain
- ☐ Color Blindness
- ☐ Headaches
- ☐ Night blindness
- ☐ Cataracts
- ☐ Mucus
- ☐ Jaw clicks
- ☐ Recurring sore throats
- ☐ Sores on lips or tongue
- ☐ Spots in eyes
- ☐ Glasses

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Fainting
- ☐ Other_____
- ☐ Low blood pressure
- ☐ Cold hands/feet
- ☐ Chest pain
- ☐ Swelling in hands/feet
- ☐ Irregular heartbeat
- ☐ Difficulty breathing
- ☐ Blood clots
- ☐ Phlebitis

RESPIRATORY

- ☐ Cough
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Difficulty in breathing when lying down
- ☐ Asthma
- ☐ Bronchitis
- ☐ Tight chest
- ☐ Production of phlegm
- ☐ Other lung problems

GASTROINTESTINAL

- ☐ Nausea
- ☐ Gas
- ☐ Bad breath
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Vomiting
- ☐ Belching
- ☐ Rectal pain
- ☐ Bloody stools
- ☐ Laxative use
- ☐ Diarrhea
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Sensitive abdomen

Bowel Movement:
_____Frequency
_____Color
_____Odor
_____Texture/Form

GENITO-URINARY

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Impotency
- ☐ Urgency to urinate
- ☐ Wake up to urinate
- ☐ Venereal disease
- ☐ Other G/U problems

PREGNANCY AND GYNECOLOGY

_____Number Pregnancies
_____Age at first menses
_____Flow (describe)
_____Number of births
____ Period (days)
____Duration
- ☐ Clots
- ☐ Changes in body/psyche prior to menstruation

- ☐ Vaginal discharge
- ☐ Birth control
- ☐ Breast lumps
- ☐ Premature births
- ☐ Miscarriages
- ☐ Vaginal sores
- ☐ Irregular periods

Last menses_____
Last PAP_____
Menopause_____

MUSCULOSKELETAL

- ☐ Neck Pain
- ☐ Muscle pains
- ☐ Back pain
- ☐ Joint pains
- ☐ Other joint or bone problems

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Anxiety
- ☐ Considered/Attempted Suicide
- ☐ Areas of numbness
- ☐ Bad temper
- ☐ Other neurological or psychological problems
- ☐ Poor memory
- ☐ Easily stressed
- ☐ Concussion
- ☐ Treated for emotional problems
- ☐ Depression

Fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance.
X-rays remain the property of the clinic.

Patient Signature_____**Date**_____**Social Security Number**_____

NAME:_____DATE:_____AGE:_____

LOSS OF FUNCTIONAL CAPABILITIES OF DAILY LIVING

DIRECTIONS: Check the ONE most appropriate statement in each section.

SECTION 1 PAIN INTENSITY

___ I have no pain
___ My pain is annoying
___ My pain is troublesome
___ My pain is miserable
___ My pain is intense
___ My pain is unbearable

SECTION 2 PERSONAL CARE

(Washing, dressing, eating, bathing, urination, defecation, brushing teeth, brushing hair)

___ I can provide for myself in a normal fashion.
___ I can provide for myself but it creates extra pain.
___ It is painful to look after myself, I am slow and careful.
___ I manage most of my personal care, but it requires some help.
___ I need help every day in most aspects of my self care.
___ I have difficulty bathing, I stay in bed and do not dress myself.

SECTION 3 COMMUNICATION

(Writing, speaking, seeing, hearing, typing)

___ I can communicate in a normal fashion.
___ I can communicate but it causes some pain.
___ My communication skills are normal but always painful.
___ Communication skills are restricted by pain.
___ Pain seriously limits my communication except for emergencies.
___ Pain prevents communication abilities totally.

SECTION 4 LIFTING

___ I can lift heavy weights.
___ I can lift heavy weights but it causes pain.
___ I cannot lift heavy weights off the floor, but if they are on a table I can manage.
___ I can manage light to medium weights, if they are conveniently positioned.
___ Pain restricts lifting to only very light weights.
___ I am unable to lift or carry.

SECTION 5 AMBULATION

(Walking, climbing stairs)

___ Pain does not prevent me walking any distance.
___ Pain prevents me from walking more than 1 mile.
___ Pain prevents me from walking more than a ½ mile.
___ Pain prevents me from walking more than a ¼ mile.
___ I require the use of crutches or a cane to assist walking.
___ I remain in bed for the most part-I crawl to the toilet.

SECTION 6 SITTING

___ I can sit in any chair as long as I like.
___ I am limited to one comfortable chair without restrictions.
___ Pain prevents me from sitting more than 1 hour.
___ Pain prevents me from sitting more than a ½ hour.
___ Pain restricts sitting for longer than 10 minutes.
___ I am unable to sit due to pain.

SECTION 7 STANDING

___ I am able to stand as long as I like.
___ I am able to stand as long as I like but it causes pain.
___ I am restricted to 1 hour of standing due to pain.
___ Due to pain, I am only able to stand for a ½ hour.
___ Pain restricts standing for longer than 10 minutes.
___ I am unable to stand due to pain.

SECTION 8 SLEEP

(Restful, nocturnal sleep patterns)

___ I sleep well in a normal fashion.
___ I can sleep well only by taking pills or using ice, heat, hot baths or _____.
___ I fail to realize 6 hours of sleep even with pills.
___ I fail to realize 4 hours of sleep even in the presence of pills.
___ I fail to realize 2 hours of sleep even in the presence of pills.
___ Pain prevents sleep.

SECTION 9 SEXUAL FUNCTION

(Normal sexual function and usual participation in sexual activities)

___ I am able to engage in normal sexual activities without pain.
___ I am able to participate sexually but it creates pain.
___ I engage normally in sexual activities but it is very painful.
___ I am restricted in activities due to pain.
___ Pain has created a near absence sex life.
___ Due to pain, I abstain from any sexual activities.

SECTION 10 SOCIAL & RECREATIONAL ACTIVITIES

(Ability to participate in group activities)

___ I am enjoying a normal, active social life with no restrictions.
___ I participate in a normal social life but pain is increased during activity.
___ The presence of pain effects only the more energetic components of social life - (bowling, golfing, dancing, etc.)
___ Pain has restricted my social life and I do not want to go out as often.
___ I am restricted to social life at home due to pain.
___ Due to pain, I have no social life.

SECTION 11 TRAVELING
(Driving, flying, riding)

___ I am able to travel anywhere without restrictions.
___ I am able to travel almost anywhere but it causes pain.
___ Pain is bad, but I can manage journeys over 2 hours.
___ Due to pain, I am limited to travel of less than 1 hour.
___ Only short, urgent trips are possible due to pain limitations.
___ I am restricted in travel due to pain other than emergencies of short distance (hospital/doctor)

SECTION 12 NON-SPECIALIZED HAND ACTIVITIES
(Grasping, lifting, tactile discrimination)

___ I can grasp and lift in a normal fashion.
___ I can utilize grip and tactile discrimination but there is some pain.
___ My grip and lift capabilities are normal but always painful.
___ Grip strength, sensations and lifting are restricted by pain.
___ Pain limits my grip and lifting to near absence.
___ Pain prevents grasping, lifting and tactile discrimination.

SECTION 13 THE EFFECTS OF MEDICATION
(Pain killers, muscle relaxants, tranquilizers, psychotropics)

___ I am able to tolerate my pain and use no pain killers.
___ I use no pain killers, even though the pain is bad.
___ I use pain killers and experience complete relief of pain.
___ I use pain killers for moderate pain relief.
___ My pain killers offer only very little relief from pain.
___ Pain killers fail to offer relief, I no longer use them.

The Washleski Chiropractic Center, P.C.
Hunterdon County Acupuncture
179 Route 31 Plaza 31
Flemington, NJ 08822
(908) 806-6171 Fax (908) 806-6433

Office Policy Review

Introduction
The purpose of this review is to allow us to serve you and get the best results. It is our experience that those patients who adhere to the following policies get the best results.

Signing In
Please sign in. When your name is called your Healthcare Assistant will direct you to the appropriate treatment room.

Lectures
It is mandatory that all patients attend our Patient Health Consultation. This consultation explains how the body functions, how Chiropractic and Acupuncture work and how results are consummated. Family and friends are welcome. There is no charge for the Patient Health Consultation.

Classes and lectures on different aspects of health care are often scheduled and may be attended at no cost. Please bring family and friends. Look for announcements regarding the classes.

Canceling or Changing Appointments
The Doctor has prepared a specific course of treatment for you to get the results we both desire. If you need to change the time of your appointment, plan to come at another time the same day. If the same day is not possible, be sure to make up the missed appointment within 1 week.

Progress Evaluations and Reexaminations
During your treatment sequence, progress evaluations and reexaminations may take place. You will be advised of your progress and need for future care.

Diets and Food Supplements
Diets should be followed and food supplements taken as recommended by the Doctor. Any problem you may have with these recommendations should be communicated to the Doctor.

Answering Service
In the event that we are unable to answer your call our phone answering machine automatically picks up the phone. Please leave a message to include your name, phone number, time you are calling and whether or not it involves an emergency.

Emergency Policy
We realize that from time to time health emergencies do arise. The Doctor calls the answering machine for messages after office hours and throughout the weekend, so if any emergency arises please call. The Doctor will call you.

Referral Policy
It makes each of us feel great that we are able to help so many. If you have a friend or relative that you feel may have a chiropractic or acupuncture problem, have them schedule an interview to talk to the Doctor at no charge. As with all our patients, if yours is a chiropractic or acupuncture problem we will let you know and, if not, be assured we will refer you to the proper specialist.

Continued…

Hours
Monday, Tuesday, Wednesday & Friday 9 A.M.-12 Noon, 3 P.M.-7 P.M.

Thursday 3 P.M.-7 P.M. Saturday 8:30 A.M.-11 A.M.

X-rays
X-rays are the property of the clinic. Please see the receptionist about copies or X-ray reports.

Payment of Bills
We will expect you to honor the financial arrangements you make with our office. If you find that you cannot fulfill the agreement you have made with us, advise our financial manager immediately so new arrangements can be made. Failure of the patient to make payment or to otherwise communicate will result in prompt legal action.

Worker's Compensation

Patient Payment: Approved services for injuries covered by Worker's Compensation are covered 100% by insurance.
Explanation of Benefits: Worker's Compensation covers all examination, treatment and x-ray costs once care has been authorized. Your employer has the right to decide whether to grant authorization for treatment or not. Authorization can also be granted by your supervisor on the job. If authorization is refused, the patient may receive treatment using alternate payment methods and plans.
Office Policy: Patients involved in a Worker's Compensation case must bring signed authorization for treatment to our office. If signed authorization for treatment is not brought to our office by your second visit, the balance will be transferred to your account. Compensation cases that involve lawsuits are expected to be paid for by your insurance or by yourself, not your attorney or court settlement. If your insurance carrier refuses payment, due to a lawsuit pending, you will be notified and the bill can be submitted to your group health insurance or paid by you. To aid us in this matter, please notify our office as to your attorney's name and address.

Personal Injury Patients: (car accident, home accident)
On most insurance policies there is a deductible. You are personally responsible for all services rendered until the deductible is met. Once the deductible is met our office policy requires you to pay the co-payment. Payment is expected at the time services are rendered.

Insurance Patients
For your convenience, we have a qualified insurance staff to handle your insurance claims. We ask that you fill out our insurance questionnaire and provide us with your insurance cards and drivers license so we can photocopy them. You are responsible for any deductible due, plus any co-payment. We will submit your insurance to your insurance carrier. You are responsible for any charges that the insurance carrier will not pay. Payment of your co-pay balance will be due at the time services are rendered or as per your financial agreements. Personal balances of the co-pay due cannot exceed $100.

Non-Insured Patients
Per visit payment is due in full. We do accept cash, check, VISA and Mastercard. Services are to be paid for on the date they are rendered. It may be necessary to do a credit check.

If a need to change your financial arrangements arises, please talk to our financial manager immediately.

Our Healthcare Assistants are here to read over these office policies with you and answer any questions you may have.

The purpose of *The Washleski Chiropractic and Acupuncture Center* is to Support Each Individual in Achieving Their Optimum Health in as Many Health Paradigms as Possible. To Educate Them so that They May Understand Health and in Turn Educate Others.

PATIENT 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 health care 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 and acupuncture 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 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 and 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 need 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 effect the use of the 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 and health care operations, Dr. Washleski has 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.

Signature of Patient_____ Date_____
Or Parent/Guardian

PLEASE PRINT NAME_____

WASHLESKI CHIROPRACTIC CENTER
ROBERT A. WASHLESKI, D.C., D.A.B.C.O

INFORMED CHIROPRACTIC CONSENT

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

- **The nature of the chiropractic adjustment.**
  I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

- **The material risks inherent in chiropractic adjustment.**
  As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients feel some stiffness and soreness following the first few days of treatment.

- **The probability of those risks occurring.**
  Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

- **The risks and dangers attendant to remaining untreated.**
  Remaining untreated allows the formations of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Robert Washleski and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____
Signature of Patient **or** Parent/Guardian Date

_____ _____
Printed Name Witness