BERGEN CHIROPRACTIC
and Sports Rehabilitation Center

Patient Information

Name: **Date of Birth:**

Address:

City: State: Zip:

Home Phone: Male ☐ Female ☐ (Physiologically)

Cell Phone: **Martial Status**

Email : S M D W

Preferred method of contact: Home Number ☐ Work Number ☐ Cell Number ☐ Email ☐

Occupation: Employer: Phone:

Address: City: State: Zip:

Emergency Contact Name: Phone:

Primary Care Physician: Phone:

Address: Permission to Contact Yes ☐ No ☐

Date of last visit

Who referred you to our office?

Health Insurance Information – Please present all cards and id for copying

Primary Insurance: Subscriber same as patient Yes ☐ No ☐

Subscriber's Name: Date of Birth:

Id / Member Number: Group Number:

Secondary Insurance:

Subscriber's Name: Date of Birth:

Id / Member Number: Group Number:

If accident related: **Date of Accident**

Insurance Name: Subscriber same as patient Yes ☐ No ☐

Subscriber's Name: Policy Number:

Adjuster's Name: Claim Number:

Phone Number: Adjuster's Fax Number:

Attorney's Name: Phone Number:

Address City State Zip

BERGEN CHIROPRACTIC
and Sports Rehabilitation Center

Please read and sign the following:

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or **terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition**, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Consent to Treat and Authorization of Payment

I the undersigned hereby authorize the Doctors of Bergen Chiropractic and Sports Rehabilitation Center to perform diagnostic tests and to administer treatment as is necessary. I also certify that no guarantee or assurance had been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize my carrier to remit payment directly to this office and I permit this office to endorse remittances as payment toward my account. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due. **However, I clearly understand and agree that all services rendered to me are my personal responsibility.**

Authorization of Release of Records:

I understand and agree to allow Bergen Chiropractic and Sports Rehabilitation Center to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize Bergen Chiropractic and Sports Rehabilitation Center to release all information necessary. I also understand that it is my responsibility to inform Bergen Chiropractic and Sports Rehabilitation Center if for any reason there is someone to whom I do not wish to have my records released to.

Patient Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care _____ **Date** _____

New Patient Intake Form

Name: _____ Date: _____

Please complete ALL the sections.

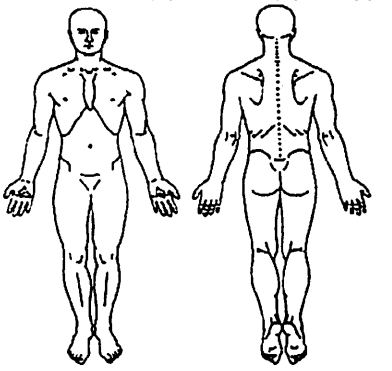
Where is your pain: _____

Pain Intensity: ***On a scale from 0 to 10 how would you grade the pain/symptom(s) with 0 being no symptoms and 10 the most severe?***

0 1 2 3 4 5 6 7 8 9 10

MARK WHERE YOU HAVE YOUR PAIN

Numbness (#) Burning "X" Stabbing (/)
Pins & Needles (o) Dull Ache (+) Pain (*)



Mechanism of Injury: ***How did you injury yourself?***

_____

Onset: ***When did your symptoms start?***

_____

Frequency: Primary signs and symptoms are present approximately:

□0-25% □26-50% □51-75% □76-100% **OF THE** □day □week □month

Timing: Primary signs and symptoms are present on what type of basis:

□Infrequent □Intermittent □Occasional □Episodic □Frequent □Constant

When are your symptoms WORST?

□morning □midday □end of the day □at night □throughout the day □at night with pain

When are your symptoms BETTER?

□morning □midday □end of the day □at night □throughout the day □at night with pain

How would you describe the quality of your pain?

□dull □sharp □sharp w/ movement □throbbing □burning □deep □aching
□tingling □stabbing □cramping □pinprick □numbness □radiating □Other: _____

Radiating: ***Does your pain travel to the following regions?***

□shoulder □upper arm □arm to hand
□buttock □upper leg □leg above the knee □leg below the knee □leg to the foot

Aggravating factors: ***Which activities aggravate (increase) your symptoms?***

□sitting □standing □walking □bending □stooping □lifting
□sleeping □sneezing □coughing □straining □reaching □twisting
□looking up □looking down □movement □rest □lying face up □driving
□typing □scooping □household chores □exercise □stair stepping

Relieving factors: Which activities relieve (decrease) your symptoms?

□sitting □standing □lying down □knees are bent up □leaning against support
□no movement occurs □movement occurs □heat is applied □ice is applied
□pain relief gel □ibuprofen is taken □medication is used □adjustments are provided
□rest occurs □stretching/exercise is used

Medications: Please check which one(s) apply to you

□ I am taking prescription medication as prescribed by my medical physician.
□ I am taking over-the-counter medication of my own accord.
□ I have received a prescription for additional services from my medical provider.
□ I am not taking any prescription medication nor any over-the-counter medication.
□ I am taking the following medications: _____

_____

_____

_____

_____

Name: Date:

Medical History

Medical Conditions (Please check which ones apply to you)

- ☐Arthritis ☐Cancer ☐Diabetes ☐Heart Disease
- ☐Hypertension ☐Psychiatric Illness ☐Skin Disorder ☐Stroke

Surgeries: (Please check which ones apply to you)

- ☐Appendectomy ☐Cardiovascular Procedure ☐Cervical Disc Procedure ☐Hysterectomy
- ☐Joint Replacement ☐Laminectomies ☐Radical prostatectomy ☐Trans-urethral prostate surgery

Allergies: (Please check which ones apply to you)

- ☐Bee Stings ☐Eggs ☐Fish and Shellfish ☐Latex
- ☐Lotions/Creams ☐Medications ☐Milk or Lactose ☐Peanut
- ☐Seasonal ☐Soy ☐Sulfites ☐Wheat/Gluten

Social History: (Please check which ones apply to you)

- ☐Caffeine used occasionally ☐Caffeine used often ☐Chew tobacco occasionally ☐Chew tobacco often
- ☐Drink alcohol occasionally ☐Drink alcohol often ☐Exercise not at all ☐Exercise occasionally
- ☐Exercise often ☐Experience stress occasionally ☐Experience stress often ☐Smoke 1 pk or less/day
- ☐Smoke 1+pk/day ☐Wear seat belt always ☐Wear seatbelt never ☐Wear seatbelt usually

Family History: (Please check which ones apply to you)

- ☐Arthritis (parent) ☐Arthritis (sibling) ☐Cancer (parents) ☐Cancer (sibling)
- ☐Cholesterol (parent) ☐Cholesterol (sibling) ☐Diabetes (parent) ☐Diabetes (sibling)
- ☐Heart problems (parent) ☐Heart problems (sibling) ☐High blood pressure (parent) ☐High blood pressure (sibling)
- ☐Psychiatric (parent) ☐Psychiatric (sibling) ☐Stroke (parent) ☐Stroke (sibling)

Substance Use: (Please check which ones apply to you)

- ☐Alcohol (past) ☐Alcohol (present) ☐Amphetamines (past) ☐Amphetamines (present)
- ☐Barbiturates (past) ☐Barbiturates (present) ☐Cocaine (past) ☐Cocaine (present)
- ☐Crystal Meth ☐Heroin (past) ☐Heroin (present) ☐Marijuana (past)
- ☐Marijuana (present)

Male Children: (Check if you are:)

- ☐Under 6 years old ☐Under 10 years old ☐Under 19 years old

Female Children: (Check if you are:)

- ☐Under 6 years old ☐Under 10 years old ☐Under 19 years old

Occupational Activities: (Please check which one(s) apply to you)

- ☐Administration ☐Business Owner ☐Clerical/secretarial ☐Computer User
- ☐Construction ☐Daycare/Childcare ☐Executive/legal ☐Food service industry
- ☐Healthcare ☐Heavy equipment operator ☐Heavy manual labor ☐Home services
- ☐Household ☐Light manual labor ☐Manufacturing ☐Medium manual labor
- ☐Military ☐Police/fire ☐Professional services ☐Retail worker

REVIEW OF SYSTEMS

Patient Name: _____ Patient File #: _____ Today's Date: ____/____/____

INSTRUCTIONS: Please fill out all of the sections. If none of the conditions apply, select "None."

Constitutional:
☐**None**
☐Chills
☐Daytime Drowsiness
☐Fatigue
☐Fever
☐Night Sweats
☐Weight Gain
☐Weight Loss

Eyes/Vision:
☐**None**
☐Blindness
☐Blurred Vision
☐Cataracts
☐Change in Vision
☐Double Vision
☐Eye Pain
☐Field Cuts
☐Glaucoma
☐Itching *(around the eyes)*
☐Photophobia
☐Tearing
☐Wears Glasses or Contacts

Ears, Nose and Throat:
☐**None**
☐Bleeding
☐Dental Implants
☐Dentures
☐Difficulty Swallowing
☐Discharge
☐Dizziness
☐Ear Drainage
☐Ear Infection*(s)*
☐Ear Pain
☐Fainting
☐Headaches
☐Head Injury *(history of)*
☐Hearing Loss
☐Hoarseness
☐Loss of Smell
☐Nasal Congestion
☐Nose Bleeds
☐Post Nasal Drip
☐Rhinorrhea *(runny nose)*
☐Sinus Infections
☐Snoring
☐Sore Throats
☐Tinnitus *(ringing in the ears)*
☐TMJ Disorder

Cardiovascular:
☐**None**
☐Angina *(chest pain or discomfort)*
☐Chest Pain
☐Claudication *(leg pain or achiness)*
☐Heart Murmur
☐Heart Problems
☐Orthopnea *(difficulty breathing while lying)*
☐Palpitations *(irregular or forceful heart beat)*
☐Paroxysmal Nocturnal Dyspnea *(shortness of breath at night)*
☐Shortness of Breath
☐Swelling of Leg*(s)*
☐Ulcers
☐Varicose Veins

Gastrointestinal:
☐**None**
☐Abdominal Pain
☐Belching
☐Black, Tarry Stools
☐Constipation
☐Diarrhea
☐Difficulty Swallowing
☐Heartburn
☐Hemorrhoids
☐Indigestion
☐Jaundice *(yellowing of the skin)*
☐Nausea
☐Rectal Bleeding
☐Abnormal Stool Caliber *(quality)*
☐Abnormal Stool Color
☐Abnormal Stool Consistency
☐Vomiting
☐Vomiting Blood

Respiration:
☐**None**
☐Asthma
☐Coughing up blood
☐Shortness of Breath
☐Sputum Production
☐Wheezing

Endocrine:
☐**None**
☐Cold Intolerance
☐Diabetes
☐Excessive Appetite
☐Excessive Hunger
☐Excessive Thirst
☐Frequent Urination
☐Goiter
☐Hair Loss
☐Heat Intolerance
☐Unusual Hair Growth
☐Voice Changes

Skin:
☐**None**
☐Changes in Nail Texture
☐Changes in Skin Color
☐Hair Growth
☐Hair Loss
☐Hives
☐Itching
☐Paresthesia (numbness, prickling, or tingling)
☐Rash
☐History of Skin Disorders
☐Skin Lesions or Ulcers
☐Varicosities

Nervous System:
☐**None**
☐Dizziness
☐Facial Weakness
☐Headaches
☐Limb Weakness
☐Loss of Consciousness
☐Loss of Memory
☐Numbness
☐Seizures
☐Sleep Disturbance
☐Slurred Speech
☐Stress
☐Strokes
☐Tremors
☐Unsteadiness of Gait

Allergy:
☐**None**
☐Anaphylaxis *(history of)*
☐Food Intolerance
☐Itching
☐Nasal Congestion
☐Sneezing

Hematology:
☐**None**
☐Anemia
☐Bleeding
☐Blood Clotting
☐Blood Transfusion*(s)*
☐Bruises easily
☐Fatigue
☐Lymph Node Swelling

Psychological:
☐**None**
☐Anhedonia *(inability to experience joy or enjoy life)*
☐Anxiety
☐Appetite Changes
☐Behavioral Change*(s)*
☐Bipolar Disorder
☐Confusion
☐Convulsions
☐Depression
☐Insomnia
☐Memory Loss
☐Mood Change*(s)*

Female:
☐**None**
☐Birth Control Therapy
☐Breast Lumps / Pain
☐Burning Urination
☐Cramps
☐Frequent Urination
☐Hormone Therapy
☐Irregular Menstruation
☐Urine Retention
☐Vaginal Bleeding
☐Vaginal Discharge

Male:
☐**None**
☐Burning Urination
☐Erectile Dysfunction
☐Frequent Urination
☐Hesitancy or Dribbling
☐Prostate Problems
☐Urine Retention

Patient Signature: _____

FOR OFFICE USE ONLY:
I have reviewed the above ROS with the above named patient:

_____ _____
Doctor Signature Date

BERGEN CHIROPRACTIC
and Sports Rehabilitation Center

2025

Cancelation Policy and Uncovered Services:

- Cancelations/Changes within 24hrs of your appointment time are subject to the Cancelation Fee.
- New Patients must give 48hrs notice from the time of your appointment
- Emergencies situations must be discussed with Reception and the Doctors.

The following are cash fees/services and not covered by insurance:

1. Cancelation fee: $68, NP: $180 Initials:____
2. Shockwave Therapy: $15 Initials:____
3. Cold Laser: $15 Initials:____
4. Taping: $10 Initials:____
5. ThermX/GameReady/NormaTec: $15 Initials:____

IF YOU DO NOT WISH TO RECEIVE THESE TREATMENTS DURING CARE, YOU MUST ALERT THE DOCTORS PRIOR TO TREATMENT BEING PREFORMED.

Patient Signature/Date:_____