JERSEY CITY CHIROPRACTIC & ACUPUNCTURE

Dr. Dominique Bariso, DC, LAc & Dr. Maria Crincoli, DC
944 Westside Avenue, Jersey City, NJ 07306
Tel: 201-432-3693 Fax: 201-432-3896

NEW PATIENT INTAKE FORM

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____/_____/_____ Gender: (circle) Female / Male / Other

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I am (circle) Under Age18 / Single / Married / Divorced / Widowed / Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No	
Primary Insurance	**Secondary Insurance**
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:
Please have your insurance card and driver's license ready so they can be copied for the clinic's records.	

How did you hear about us? □ Website □ Public Event □ Referred by _____

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Reason for today's visit:

Describe the reason(s) for your visit today:

_____

_____

Are you here because of an accident? _____ If so please describe: _____

When and how did your symptoms start?_____

How often do you experience symptoms? *(circle one)* ***Constantly*** ***Frequently*** ***Occasionally*** ***Intermittently***

Describe your symptoms? *(circle all that apply)* ***Sharp*** ***Dull ache*** ***Numbing*** ***Burning*** ***Tingling*** ***Shooting***

Are your symptoms? *(circle one*) ***Getting better*** ***Staying the same*** ***Getting worse***

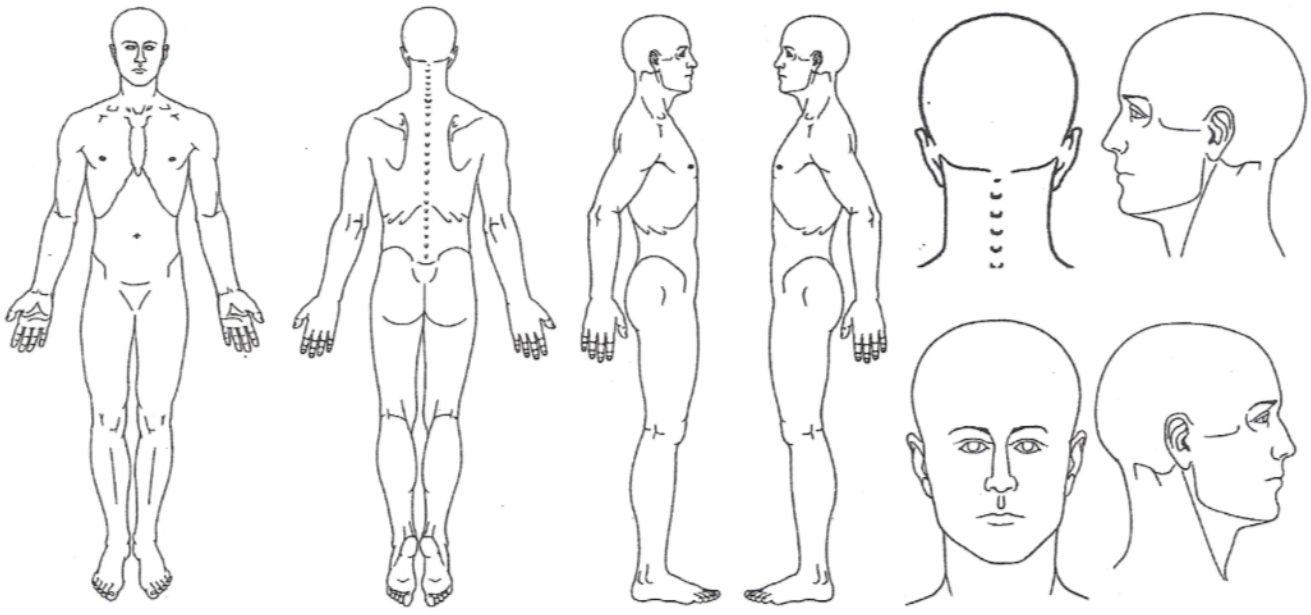
Do your symptoms interfere with any of the following? *(circle all that apply)* ***Work*** ***Sleep*** ***Daily Activities***

Have you experienced these symptoms in the past?_____

Have you seen another doctor or healthcare provider for these symptoms?_____

Have you seen a chiropractor before? □ Yes □ No Have you seen an acupuncturist before? □ Yes □ No

Mark any area(s) of discomfort with the following key: ***A =Ache*** ***N =Numbness*** ***B = Burning*** ***T = Tingling*** ***S = Stiffness*** ***O = Other***



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HEALTH QUESTIONNAIRE

Height: _____ Weight: _____

Medications: *list all prescription or non-prescription medications, vitamins, or herbs you take, list dosage, and for what condition*

_____

_____

_____

Surgeries or hospitalization: *list any surgeries or hospitalizations and the date of each*

_____

_____

_____

Allergies: *list anything you are allergic to* _____

Family History: *list all major diseases (CANCER, DIABETES, HEART DISEASE) and the relation of the individual to you*

_____

_____

_____

Do you exercise? □ Yes □ No Hours per week _____ What activity(s) _____

Are you dieting? □ Yes □ No What is your typical diet like? _____

Do you smoke currently? □ Yes □ No Did you smoke in the past? □ Yes □ No _____ packs per day for _____ years

Do you drink alcoholic beverages? □ Yes □ No Did you drink in the past? □ Yes □ No _____ drinks per day for _____ years

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics

For Women: Are you pregnant or nursing? □ Yes, _____ weeks □ No # of pregnancies _____ # of children _____

Additional comments you would like the doctor to know regarding your health: _____

_____

Primary care physician: _____ Date last seen: _____

May we update them on your condition? □ Yes □ No

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ACUPUNCTURE QUESTIONNAIRE

SYMPTOMS: *Check off each symptom you CURRENTLY have. Leave blank if not applicable*

LIVER / GALLBLADER
_____ Irritability / Easily Angered
_____ Depression
_____ Headaches / Migraines
_____ Visual Problems / Blurry Vision
_____ Red / Dry / Itchy Eyes
_____ Dizziness
_____ Feeling of Lump in Throat
_____ Clenching Teeth at Night
_____ Muscle Cramps / Twitching
_____ Menstrual Cramps
_____ Tension / Feeling Stress
_____ Poor circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER
_____ Urinary Retention / Lack of control
_____ Bladder infection
_____ Weakness / Pain in Lower Back
_____ Decreased Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Hair Loss
_____ Hearing Loss / Tinnitus
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flashes / Night Sweating

HEART / SMALL INTESTINE
_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams

LUNG / LARGE INTESTINE
_____ Dry Cough
_____ Cough with Sputum
_____ Nasal discharge / Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red, or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever That Comes & Goes

SPLEEN / STOMACH
_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema / Swelling
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia / Insulin Sensitivity
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Hemorrhoids
_____ Constipation
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Overthinking
_____ Brain Fog
_____ Tendency to Gain Weight

BODY TEMPERATURE
_____ Cold entire body
_____ Cold hands and feet
_____ Hot all day
_____ Hot only in afternoon
_____ Hot only at night
_____ Normal

AVERAGE ENERGY LEVEL (circle) Low 1 2 3 4 5 6 7 8 9 10 High

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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed _____ Date _____

Consent for Examination

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests, and procedures for the above minor patient

Signed _____ Date _____

Authorization for Contact

By signing below, I authorize Jersey City Chiropractic (JCC) to use my name, address, telephone number, and/or email address to contact me regarding appointments, newsletters, products, and events. The use of this information is intended to make my experience with JCC more efficient, productive, and to further enhance my access to quality health care. If I choose not to authorize this information use, my decision will have no adverse effect on my care or my relationship with the staff at Jersey City Chiropractic. My authorization may be revoked at anytime via writing.

Signed _____ Date _____

Financial Policy

CHIROPRACTIC CARE:

Regarding ALL insurance: *We accept insurance for chiropractic care and will bill your insurance carrier. We strongly suggest you contact your insurance carrier to verify your benefits. Payment of non-covered services and co-payments is expected at time of service. If your insurance carrier fails to pay for services within ninety days, you are responsible for payment and any outstanding balances.*

Regarding Medicare: *Medicare pays for a limited portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include an initial exam, other therapies, services, and goods that may be necessary during care. Payment for non-reimbursable care is your responsibility.*

Regarding Personal Injury, Worker's Compensation, or Litigation: *If an attorney is involved, you are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within 14 days, the fee for all services rendered is your responsibility.*

ACUPUNCTURE CARE: *Most insurance companies do not cover acupuncture, however if yours does, we will gladly bill your carrier. We strongly suggest you contact your insurance carrier to verify your benefits. If your insurance carrier fails to pay for services within ninety days, you are responsible for payment and any outstanding balances. If your insurance does not cover acupuncture, you are responsible for payment at time of service.*

For those without insurance: *We accept cash, checks, and credit/debit cards. Payment is expected at time of service.*

By signing below, I understand the financial policy, and that I am financially responsible for all unpaid balances for my care.

Signed _____ Date _____

Assignment of Benefits & Release

By signing below, I authorize Jersey City Chiropractic (JCC) to release medical records required by my insurance company(s). I authorize my insurance company to pay benefits directly to JCC and I agree that a reproduced copy of this authorization will be as valid as the original. I agree that I will be responsible for any collection agency or attorney fees incurred.

Signed _____ Date _____