BENTE FAMILY CHIROPRACTIC
249 KINDERKAMACK ROAD
WESTWOOD NJ 07675

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NEW PATIENT DATA FORM

PATIENT INFORMATION

LAST NAME _____ **SOC SEC #** _____

FIRST NAME _____ **DOB** _____

ADDRESS _____ **CITY/ST/ZIP** _____

PHONE _____ **HOME WORK CELL (circle one)**

E-mail _____

YOUR PREFERRED WAY OF BEING CONTACTED: HOME PHONE CELLPHONE SMS E-MAIL (circle one)

EMPLOYER _____ **PHONE #** _____

EMPL. ADDRESS _____ **CITY/ST/ZIP** _____

SPOUSE/PARENT/GUARDIAN INFORMATION

LAST NAME _____ **SOC SEC #** _____

FIRST NAME _____ **DOB** _____

ADDRESS _____ **CITY/ST/ZIP** _____

PHONE _____ **HOME WORK CELL (circle one)**

E-mail _____

EMPLOYER _____ **PHONE** _____

ADDRESS _____ **CITY/ST/ZIP** _____

INSURANCE AND PRIMARY CARE PHYSICIAN (PCP) INFORMATION

INSURANCE CO. _____ **SUBSCRIBER ID** _____

EMPLOYER _____ **GROUP NO.** _____

MEMBER/POLICY HOLDER NAME _____

PCP NAME _____ **PCP PHONE** _____

ADDRESS _____ **CITY/ST/ZIP** _____

I authorize the staff of Bente Family Chiropractic (hereafter referred to as "BFC") to perform any necessary services needed during diagnosis and treatment. I authorize BFC and its staff to release any information required to process insurance claims.
I understand and agree that health and accident insurance policies are arrangements between insurance carrier(s) and myself.
I authorize payment from my insurance carrier(s) directly to the BFC office with the understanding that all monies will be credited to my account upon receipt. However, I understand and agree that all services rendered me are billed directly to me and that I am personally responsible for payment.
The information on this form was completed correctly, and I understand that it is my responsibility to inform the BFC office of any changes in my medical status or my insurance information details.

Please sign, complete Patient Intake Questionnaire and bring both forms, all pages, to the office for your first visit. Thank you!

PATIENT SIGNATURE _____ **DATE** _____

NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name _____

Reason for Visit _____

☐ Pain Symptoms ☐ Wellness Visit ☐ Auto Accident

☐ Work Related Injury ☐ Sports Injury ☐ Other Injury

Date of injury/accident/first symptoms _____

Auto Accident - were you

☐ Driver ☐ Passenger Front ☐ Passenger Rear Seat ☐ Pedestrian/Bicyclist

Were you wearing a seat belt? ☐ Yes ☐ No
Is there a police report? ☐ Yes ☐ No
Did you receive aid at the scene? ☐ Yes ☐ No
Were your taken to the hospital? ☐ Yes ☐ No
Did you see your Primary Care Physician for injuries related to this accident? ☐ Yes ☐ No

Did you hit any of the following:
☐ Air Bag ☐ Steering Wheel ☐ Side Door
☐ Dash Board ☐ Windshield ☐ Other

Briefly describe how the accident happened: _____

Work Related Injury

Your Job Title _____ **Employer** _____ **Years in Pos.** _____

Briefly describe your normal work activities _____

Explain in detail what caused the injury _____

Did you file a Workmans Comp Insurance Claim? ☐ Yes ☐ No
Were your taken to the hospital? ☐ Yes ☐ No
Did you see your Primary Care Physician for injuries related to this accident? ☐ Yes ☐ No

Sports or other Injury

Explain in detail what caused the injury _____

Where and when did the injury occur? _____

Were your taken to the hospital? ☐ Yes ☐ No
Did you see your Primary Care Physician for injuries related to this accident? ☐ Yes ☐ No

SYMPTOMS

Patient Name _____

Primary Symptoms - check all that apply

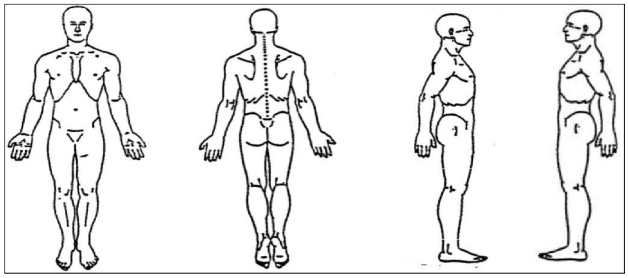
☐ HEADACHE	☐ MIGRAINES	☐ NECK PAIN	☐ NECK STIFFNESS	☐ SHOULDER PAIN
☐ ARM PAIN	☐ LOW BACK PAIN	☐ HIP PAIN	☐ LEG PAIN	☐ BACK PAIN
☐ SORENESS	☐ DISCOMFORT	☐ NUMBNESS	☐ TINGLING	☐ DIZZINESS
☐ FATIGUE	☐ WEAKNESS	☐ MEMORY LOSS	☐ HEARING LOSS	☐ DEPRESSION
☐ ELBOW PAIN	☐ KNEE PAIN	☐ FEVER	☐ SWEATING	☐ SLEEP PROBLEMS

☐ OTHER: _____

Where specifically does it hurt?

☐ NECK	☐ UPPER BACK	☐ MID BACK	☐ LOWER BACK	☐ LEFT HIP	☐ RIGHT HIP
☐ LEFT SHOULDER	☐ RIGHT SHOULDER	☐ LEFT ARM	☐ RIGHT ARM	☐ LEFT ELBOW	☐ RIGHT ELBOW
☐ LEFT LEG	☐ RIGHT LEG	☐ LEFT KNEE	☐ RIGHT KNEE	☐ LEFT ANKLE	☐ RIGHT ANKLE
☐ HEAD	☐ EYES	☐ EARS	☐ CHEST	☐ ABDOMEN	☐ BUTTOCKS

Please describe pain and place an "X" on the graphic below to indicate location of pain.



Severity

☐ Mild ☐ Mild to Mod. ☐ Moderate
☐ Moderate to severe ☐ Severe

Frequency

☐ Once ☐ Intermittent ☐ Occasional
☐ Frequent ☐ Constant

Type

☐ Dull ☐ Medium ☐ Sharp
☐ Stabbing ☐ Burning

Time - Pain is worse (check all that apply)

☐ Morning ☐ Midday ☐ After Work ☐ Evening ☐ Nighttime

Describe on a scale of 1 (none to very little) to 10 (severe) how you rate the intensity of your pain:

Circle one: 1 2 3 4 5 6 7 8 9 10

Have your had this condition in the past? ☐ Yes ☐ No

Have you been treated for the current condition in the past? ☐ Yes ☐ No

When? _____ **By Whom?** _____

What treatment was prescribed/received: _____

What Activities of Daily Living (ADL) are you unable to perform due to your pain?

☐ Sleeping	☐ Walking	☐ Standing	☐ Sitting	☐ Running
☐ Bathing	☐ Showering	☐ Dressing	☐ Put on Shoes	☐ Toileting
☐ Self Care	☐ Family Care	☐ Child Care	☐ Home Care	☐ Driving
☐ Working	☐ Lifting	☐ Desk Work	☐ Traveling	☐ School
☐ Climbing	☐ Cleaning	☐ Gardening	☐ Concentrating	☐ Other

Describe how the pain affects your Activities of Daily Living:

_____

How are your symptoms changing? ☐ Getting better ☐ No Change ☐ Getting worse

Additional Complaints: _____

_____

MEDICAL HISTORY

What other conditions have you been treated for in the past? _____

_____

What if any surgical procedures have you had? _____

_____

History of past or present illness, injury and other health issues - check all that apply

☐ Diabetis	☐ Arthritis	☐ AIDS	☐ Sciatica	☐ Bursitis
☐ Alzheimers	☐ Kidney Dis.	☐ Gout	☐ Amputation	☐ Ulcers
☐ Cancer	☐ Heart Attack	☐ Stroke	☐ COPD	☐ Scoliosis
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting	☐ Varicose Veins
☐ Fainting	☐ Sweats	☐ Chills	☐ Nervousness	☐ Eczema
☐ Bleeding	☐ Tonsilitis	☐ Earache	☐ Hemorrhoids	☐ Neuro-Muscular Disease
☐ Osteoporosis	☐ High Blood Pressure	☐ Neuralgia	☐ Convulsions	☐ Prostate
☐ Pregnancy				

☐ Other: _____

Family history - is there any history in your family of any of the above mentioned or other health conditions? If yes, please list them:

_____

List any current allergies _____

_____

Please list any medications, herbal remedies and supplements you are taking:

_____

_____

Lifestyle - check all that apply

☐ Smoke Cigarettes _____ packs/day ☐ Smoke Cigars ☐ I don't smoke

☐ Alcoholic Drinks _____ per day _____ per week ☐ I don't drink alcohol

☐ Beer, Wine _____ per day _____ per week ☐ I don't drink wine or beer

☐ I have a history of recreational drug use. ☐ I do not have a history of recreational drug use.

☐ I am pregnant. Due Date: _____

Any other comments that might help us devise the most suitable treatment plan? _____

_____

_____

_____

_____

Please sign and date this form, confirming that all information contained on all 5 (five) pages are correct and complete.

PATIENT SIGNATURE _____ **DATE** _____