WELCOME TO OUR OFFICE

Name_____ Office ID#_____
Address_____ City/ State/Zip_____
Home #_____ Cell#_____ Work #_____ E-Mail_____
Occupation_____ SS# _____
Birthday_____ Age_____ Marital Status_____ # of children _____
Emergency Contact_____ SpouseName_____ Occupation _____
Child's Name_____ Age_____ Child's Name_____ Age _____
Child's Name_____ Age_____ Name of patient who referred you_____

Major Complaint_____
Other Complaints_____ How long with issue _____

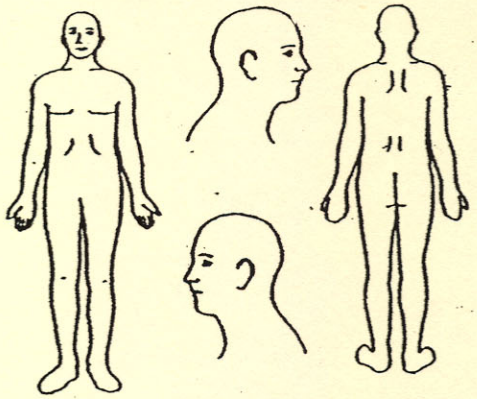
This new / old issue was / was not treated before
If treated what was done _____
Name of Doctor_____
Previous surgery (list) _____
_____
Last Chiropractor _____
Last Adjustment _____
Last Spinal X-ray _____
Medications now taking _____
Last antibiotic / date_____

From birth to present please list and date the following
1)Car accident_____
_____
_____
2)Last Fall/ Injury_____
_____
_____
3)Special Interest/Sports_____
_____
_____

Current stress(work, family)_____
How do you deal with stress_____
_____
Type of daily exercise_____
Daily vitamin intake_____
Daily caffeine intake_____

How many glasses water / day_____
Do you drink alcohol_____
Do you smoke_____ppd_____trying to quit_____

Please mark your areas of pain on the figure below



Please check off any symptoms you may be experiencing

__Neck pain	__Low Back Pain	__Leg Problems
__Shoulder Pain	__Arm Pain	__Numbness
__Allergies	__Asthma	__Stiff Joints
__Nausea	__Poor Digestion	__Eczema
__Diarrhea	__Constipation	__Thyroid Problems
__Headaches	__Dizziness	__Kidney Disease
__Diabetes	__Blood Pressure	__Hearing Loss
__Frequent Colds	__Ear Infections	__Menstrual Problems
__Depression	__Fainting	__Heart Problems
__Lung Disease	__Osteoporosis	__Restriction of Daily Activities

Sign and Date_____

Our mission is to educate and adjust as many families as possible toward Optimal health through natural chiropractic care

DOCTORS INITIAL EXAM

Cervical ROM Date: _____
(50) Flexion _____
(60) Extension _____
(45) R Lat Flex _____
(45) L Lat Flex _____
(80) R Rotation _____
(80) L Rotation _____

Dorsal ROM
(60) Flexion _____
(25) Extension _____
(25) R Lat Flex _____
(25) L Lat Flex _____
(30) R Rotation _____
(30) L Rotation _____

Orthopedic Test Date: _____

F. Compression	(L)____	(R)____
Sh. Depression	(L)____	(R)____
Kemps	(L)____	(R)____
SLR	(L)____	(R)____
Soto Hall	(L)____	(R)____
Ely's	(L)____	(R)____

Weight Distribution (L)____(R)____

Comment:_____
_____
_____
_____

FOR OFFICE USE ONLY:

INITIAL EXAM_____
POSTURE_____
_____
_____
WT SCALES L)_____ R)_____
BSE 1_____ BSE2_____
_____ _____
_____ _____
RE-EXAM_____

BSE3_____ BSE4_____
_____ _____
BSE 5_____ BSE6_____
_____ _____
REEXAM_____

Referrals _____ _____
_____ _____
Workshop Date: 1)_____ 2)_____

Exercise Regimen : ____Ball ____Wobble Board
____Stretches LB/ Neck

Cervical Traction:____# min, ____#min, ____#min

Care Plan_____
Prepay$_____ Monthly_____/____mos
Reactivation date:_____

HEALTH CARE FAMILY AUTHORIZATION FORM

Patient's Name
(Parents)_____

Children:_____ _____

Patients SS# _____ Date of Birth _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES SHORE HANDS FAMILY CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

- ❑ I give permission to Shore Hands Family Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards information about treatment alternatives or other health related information.

- ❑ If Shore Hands Family Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

(OPEN ROOM AUTHORIZATION _ OPTIONAL)

- ❑ I give Shore Hands Family Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

- ❑ By signing this form you are giving Shore Hands Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Patient signature:_____ Spouse:_____
Guardian of_____

Date: _____

SHORE HANDS FAMILY CHIROPRACTIC
61 MEMORIAL PARKWAY
ATLANTIC HIGHLANDS NJ 07716

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is made by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it Nor do we advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments

I,_____ have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I there fore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to Evaluate and Adjust a Minor

I,_____ being the parent or legal guardian of _____
Have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my Knowledge I am not pregnant and the above doctor and his staff associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_____

_____ _____
(Signature) (Date)