NATURAL HEALTH CENTER

1033 Clifton Avenue   973-470-0687   Clifton, N.J. 07013

APPLICATION FOR SERVICES

Date: __________________________ Primary Care Physician: _________________________________

Name: ____ Ms. Mrs. Mr. Miss.

Is this your legal name? Y N If not, what is your legal name? ________________________________

Address:____ Social Security Number:___________________

City:__________________________________ State:_______ Zip Code:_______________ Sex M F

Home Phone ( ) ____________________________ Cell Phone ( )_______________________

Email address____________________________________ Birthday _______________Age________

Emergency contact_________________________ Contact's Cell Phone__________________________

Marital status: Married Single Significant Other Widowed Separated Divorced

Name of Spouse ____

Describe health of spouse ____

Do you have children? _____ male ____ female Health of Children _______________________

List any other family members or friends involved in your health decisions: ________________________

____

Occupation: ______________________________Business/Employer: ____________________________

Referred to Clinic by Family/Friend- Name ____

Referred to Clinic by Doctor/Hospital- Name ____

Chose Clinic because of Dinner event Mailer TV Newspaper Other_________________________

Are you insured: Y N Primary Company name ____

Secondary Company name ____

Chief complaint (reason you are here): ____

____

How did your problem begin? ____

↑ Auto accident ↑Work related accident ↑Other type of accident

↑ Gradual Sudden Cumulative Trauma Repetitive Stress No specific reason

How long have you had this problem? ____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? ¨ Yes ¨ No If so please describe:

____

____

What have you tried for treatment that did not work?

____

____

Have you seen a M.D., P.T., or a D.C. *for this problem*? Yes No

Doctor's Name	Specialty	Year(s) Seen

Please list any *other* Doctors you have seen in the last year or are seeing now____________________

____

How does this problem interfere with your daily life?

____

____

____

Have you been worried about getting this problem resolved? Yes No If yes, please describe:

____

____

____

What is your main concern about your symptoms?

____

____

____

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

1	2	3	4	5	6	7	8	9	10

What prescriptions or over-the-counter medications are you taking?

Medication	Reason for Taking

Have you ever been treated by a Chiropractor for this or another problem? Yes No

Chiropractor's name and address____

Reason for treatment____

Date of first treatment___________ Date of last treatment____________

Number of treatments ____ How often did you see the Doctor?____________Did it help? Y N

Have you ever been treated by an Acupuncturist for this or another problem? Yes No

Acupuncturist's name and address____

Reason for treatment____

Date of first treatment_________ Date of last treatment__________ Number of treatments ____

How often did you see the Acupuncturist? ____________Did it help? Y N

Do you have, or have you been treated for any *other* health conditions in the last year?
___Yes ___No If Yes, explain: ____
____
____

List any major illnesses you have or had with approximate dates: Diabetes – Type One
Diabetes – Type Two Cancer Other ____
____

Have you ever had any car accidents? YES NO _____________________________________
or other accidents or falls?: YES NO ____

Any ER or hospitalization in the last 5 years?_____________________________________

Please tell us about any surgery you have had:
Pacemaker Defibrillator other implanted device
Appendectomy Tonsillectomy Gall Bladder Hernia Spinal
Other surgery or Broken Bones?____

Please list any x-rays, MRIs, CT scans, bone density, bone scans that you have had:

Area of body	Type of Test	Where was it done?	When	Results/do you have the report

What is your physical activity at work?

↑ Mostly sitting ↑Light manual ↑Moderate manual ↑Heavy manual

Do you exercise?

↑No regular exercise ↑1-2 times/week ↑3-4 times/week ↑5-7 times/week
↑Cardiovascular ↑Stretching ↑Weight Machine ↑Free Weights
↑Sports____

What is your general stress level?

↑No stress ↑Minimal stress ↑Moderate Stress ↑Greatly stressed

Do you take vitamins, herbs or nutritional supplements?

↑No ↑Yes If yes, what do you take? _______________________________

ASIDE FROM YOUR MAJOR COMPLAINT ABOVE; WHICH OF THE FOLLOWING DO YOU EXPERIENCE? “R” = right “Left” = left

	PAIN	DISCOMFORT	TENDERNESS	TIGHTNESS	MUSCLE SPASM	LACK OF MOTION	NUMB	TINGLING	PINS & NEEDLES	WEAKNESS	INFLAMMATION
HEAD	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
NECK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
UPPER BACK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
MID BACK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
RIBS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
LOW BACK	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
HIPS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
UPPER LEGS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
KNEES	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
LOWER LEGS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
ANKLES	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
FEET/TOES	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
SHOULDERS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
ARMS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
ELBOWS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
FOREARMS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
WRISTS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
HANDS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L
FINGERS	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L	R L

ON THE NEXT PAGE:

MARK ANY OF THE CONDITIONS OR PROBLEMS THAT YOU HAVE **NOW** WITH AN **“N”**
MARK ANY OF THE CONDITIONS YOU HAD IN THE **PAST** WITH A **“P”**

General	Neurological	Respiratory
Fatigue, tiredness	Fainting spells	Chronic obstructive disease
Weakness	Seizures	Wheezing
Chills	Paralysis	Chronic cough
Fever	Dizziness	Coughing up blood
Night sweat	Tremor	Asthma
Appetite change	Chronic headaches	Shortness of breath
Lived in foreign country	Poor balance	TB
Unexplained weight loss	Fractured back or neck	Lung Cancer
Unexplained weight gain	Numbness of face / arm / leg	Emphysema
Generalized pain	Peripheral neuropathy	Chronic bronchitis
Unable to tolerate heat	Stroke or Mini – stroke	Pneumonia
Unable to tolerate cold	Forgetfulness	Fluid in lungs
Sedentary lifestyle	Epilepsey	Need to sleep sitting up
Active lifestyle	MS	Other ___________________
Other ________________	Other ____________________	
Musculoskeletal	**Cardiac**	**Vascular**
Arthritis	Angina (chest pain)	Leg pain walking over 1 block
Bursitis	Rapid heartbeat	Leg pain walking less than block
Joint swelling	Atrial fibrillation	Pain in legs while at rest
Joint stiffness	Past heart attacks	Blood clots in legs
Joint Pain	Heart murmur	Deep
Muscle aches	Congestive heart failure	Superficial
Muscle weakness	High blood pressure	Cold feet or hands
Leg cramps	Aortic aneurysm	Amputation of toes
Neck Disk Problem	Other heart problem	Amputation of feet or legs
Low Back Disk Problem	Pacemaker	Peripheral vascular disease
Walking Problem	Defibrillator	Ulcers of lower legs
Scoliosis	Other_________________	Varicose viens
Other ________________		Aneurysm of arteries
		Other ____________________
Gastrointestinal	**Genitourinary**	**Skin**
Diarrhea	Hesitancy / urgency of urine	Rashes
Constipation	Need to urinate often at night	Tumors
Stool changes	Loss of bladder control	Sensitivity to sunlight
Bowel habits changes	Difficult urination	Malignant melanoma
Hemorrhoids	Renal failure	Squamous cell carcinoma
Indigestion	Impotence	Basal cell carcinoma
Ulcers	Current Dialysis	Easy bruising
Irritable bowel	Renal transplant	Fungal infections
Colon polyps	Prostate enlargement	Non-healing sores
Cramps/ pains	Cancer of bladder/ kidneys	Excessive rough or dry skin
Cancer of the stomach or bowel	Other ___________________	Itching skin
Diverticulitis		Other ____________________
Heartburn/GERD		
Other ___________________		
Psychiatric	**Blood & Lymph**	**Eyes, Ears, Nose and Throat**
Depression	Anemia	Pain
Anxiety (abnormal)	Blood disease	Hearing loss
Panic attacks	Transfusions	Polyps
Alzheimer's	Leukemia	Vertigo
Confusion (abnormal)	Bone marrow test	Ringing in ears (tinnitus)
Hospitalized for nervousness	Long term Coumadin use	Sinus infections
Substance abuse	Blood clotting problems	Deafness
Anorexia	Other ________________	Allergies
Other ___________________		Other _________________
Thyroid problems	Hepatitis	
Diabetes – Type one	Gallbladder Disease	
Diabetes – Type two		

Non-Medicare patients please go to next page.

FOR MEDICARE PATIENTS ONLY

Past or Present Symptoms and Conditions

Please check the box indicating whether you have or have had any of the following at any time.

Symptoms/Conditions	**Past**	**Present**	
Rheumatoid arthritis			
Ankylosing spondylitis			
Bone fractures			
Malignancy of the spine			
Infection of the bones or joints			
Myelopathy			
Cauda Equina syndrome			
Carotid artery problems			
Aneurysm			
Instability of joints			
Benign tumors of the spine			
Osteoporosis			
Bleeding disorders			
Nerve problems			
Anticoagulants/blood thinning therapy			
Dizziness			
Drop Attacks			
Double vision			
Difficulty speaking			
Difficulty swallowing			
Nausea			
Numbness			
Nystagmus			
Neck pain			
Jaw pain			
Headaches			
Fainting spells			
High blood pressure			
Stroke			
Transient ischemic attacks			

Page 7 is for Medicare Patients only.

Social and Occupational History

Level of education ____

Job description____

Work schedule____

Recreational activities____
Amount of exercise: __________________________ Alcohol use: ____________________________
Tobacco use: _______________________________ Drug use: _____________________________
Coffee use: _________________________________

Any household pets or other animals you or family members are in close contact with:
____

Family History

Relationship	Health Problem(s)- such as heart disease, diabetes, arthritis, osteoporosis, cancer etc.
Father	
Mother	
Brother	
Sister	

Is there anything else you wish to tell the Doctor?____
____
____
____

Please read and sign the following certification:

I certify that the information I have given on the preceding pages is true and complete. I have not withheld any information relative to my health or any condition, problem or symptom. I hereby authorize The Natural Health Center of Clifton, its Doctors and Staff, to provide me with care in accordance with New Jersey State's statutes.

____ ____________________________
Patient's (Parent/Guardian) Signature Date

THANK YOU!

The Natural Health Center Doctor and Staff