Goal/Lifestyle Questionnaire

Name:_____ **Today's Date:**_____

Occupation:_____ **Allergies:**_____

What would you like to "get back" to doing? Please be specific.

_____

_____

Describe your commute. How far do you travel each day and for how many hours? How do you get to work? (i.e. car/train/bus)

_____

_____

What are the physical demands of your occupation?

_____

_____

Do you take vitamins? If so, which specific ones are you taking?

_____

_____

Describe your daily eating habits. Would you like to gain or lose weight? If so, how many pounds and by which date?

_____

_____

Are there any tasks at home that require the help of someone else? Do you have any children?

_____

_____

What do you do in your free time?

_____

_____

Did/do you play any sports? If so, at what position and level do you compete?

_____

_____

What are the goals of your life?

_____

_____

NJ Spine and Wellness Center

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300 Perrine Road, Suite 305, Old Bridge, NJ 08857 – Phone: 732-952-2292
210 Mounts Corner Drive, Freehold, NJ 07728 – Phone: 732-414-2700

Welcome to Our Office! Today's Date _____ / _____ / _____

Whom may we thank for referring you to our office? _____

PERSONAL INFORMATION

Name LAST: _____ FIRST _____ MIDDLE _____

Birth Date _____ / _____ / _____ Age _____ Sex PLEASE CIRCLE Male Female Social Security # _____- _____-_____

Address _____ Apt # _____ City _____ State _____ Zip _____

Phone # HOME _____ CELL _____ WORK _____

Email Address _____ Height _____ Weight _____

Marital Status PLEASE CIRCLE Single Married Widowed Divorced Separated

Spouses Name LAST _____ FIRST _____ # of Children _____

Insurance Company _____ ID Number _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

EMERGENCY CONTACT

Name LAST: _____ FIRST _____ Relationship _____

Phone # HOME _____ CELL _____ WORK _____

Health History

FILL OUT CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE.

Primary Care Doctor Name _____ Date of Last Visit _____ /_____ /_____

Current Medication(s) LIST **ANY**/**ALL** MEDICATIONS YOU ARE **CURRENTLY** TAKING. BE SPECIFIC. _____

_____

Pharmacy:_____ Phone Number: _____ Address: _____

Illness(es) **LIST** ALL HEALTH CONDITIONS. _____

_____

Surgery(is) **LIST** ALL SURGICAL PROCEDURES. WRITE THE **DATE** OF THE PROCEDURE IMMEDIATELY AFTERWARD. _____

_____

Allergies **LIST** ALL KNOWN ALLERGIES. _____

_____

Family History **LIST** ALL KNOWN FAMILY HEALTH CONDITIONS. _____

_____

Injury(is) MARK OR LIST ALL INJURIES. WRITE THE **DATE** OF THE INJURY IMMEDIATELY AFTERWARD.

Fall ___ /___ /___	Broken bones ___ /___ /___	Loss of Consciousness ___ /___ /___
Head Injury ___ /___ /___	Back/Neck Injury ___ /___ /___	Motor Vehicular Crash ___ /___ /___

Social History

Tobacco	☐ Do not use tobacco	☐ Smoke/Chew: # _____ per Day	☐ Live with a Smoker	☐ Quit Smoking
Alcohol	☐ Do not use Alcohol	☐ # _____ per Week	☐ # _____ per Month	

Review of Systems

PLEASE CIRCLE THE ITEMS BELOW THAT APPLY TO YOU.

Nervous System

☐ Dizziness	☐ Seizures	☐ Loss of Memory	☐ Slurred Speech	☐ Loss of Consciousness
☐ Strokes	☐ Tremor	☐ Limb Weakness	☐ Fatigue	☐ Sleep Disturbance
☐ Stress	☐ Numbness	☐ Headache	☐ Loss of Balance	☐ Tinnitus/Ringing in Ears

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Respiration

☐ Asthma ☐ Cough ☐ Wheezing ☐ Sputum Production ☐ Shortness of Breath

Cardiovascular

☐ I DENY Any Symptoms ☐ Chest Pain ☐ Swelling of Legs ☐ Low Blood Pressure ☐ Claudication (Leg Pain/Ache)
☐ Palpitations ☐ Varicose Veins ☐ High Blood Pressure ☐ Shortness of Breath

Gastrointestinal

☐ Diarrhea ☐ Indigestion ☐ Abnormal Stool ☐ Vomiting Blood ☐ Weight Changes
☐ Belching ☐ Vomiting ☐ Abdominal Pain ☐ Constipation ☐ Difficulty Swallowing
☐ Nausea ☐ Heartburn ☐ Ulcers

Psychologic

☐ Irritability ☐ Insomnia ☐ Memory Loss ☐ Behavioral Change ☐ Bipolar Disorder
☐ Anxiety ☐ Depression ☐ Mood Changes ☐ Loss or Change in Appetite

Immune

☐ Itching ☐ Anaphylaxis ☐ Food Intolerance ☐ Nasal Congestion ☐ Rash

PLEASE CIRCLE THE TYPE OF CARE THAT MEETS YOUR NEEDS:

RELIEF CARE
is the care necessary to get rid of your symptoms or pain, but not the cause of it?

RESTORATIVE CARE
is to get rid of the symptoms or pain while correcting the cause of the problem

WELLNESS CARE
is periodic treatments that help avoid problems in the future.

PRESENT HEALTH CHALLENGE(s)

IF YOU HAVE NO SYMPTOMS OR COMPLAINTS, AND ARE HERE FOR WELLNESS CARE, CHECK HERE

UNWANTED HEALTH CHALLENGE(s)

Explain why you are here today _____

_____

_____

_____

Has it ever occurred before? Yes No

When do you think this complaint started? _____

_____

_____

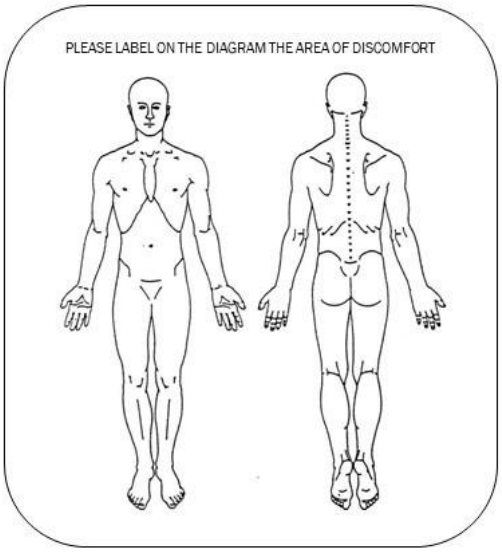
Date of Auto Crash or Work-Related Injury _____ /_____ /_____

Has the accident been reported: ☐ NO ☐ TO EMPLOYER ☐ TO AUTO CARRIER

Have you regained an attorney? ☐ NO ☐ YES

Attorney Name & Phone Number: _____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT



PLEASE CHECK THE APPROPRIATE CIRCLE & COMPLETE THE BLANKS.

Body Area(s) Involved ☐ Neck ☐ Back ☐ Head ☐ Other _____

Mechanism of Onset ☐ Auto ☐ Work ☐ Slip/Fall ☐ Other _____ Onset Date ___ /___ /___

Current Symptoms ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness ☐ Other _____

Quality ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

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Timing ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity ☐ Constant ☐ Intermittent

What Makes It Worse? _____

What Makes It Better? _____

Level of Impairment Due to Symptoms CIRCLE THE APPROPRIATE LEVEL WITH **0=NONE/10=EXTREME**

While Resting	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10

Headaches Location ☐ Occipital ☐ Frontal ☐ Left Temporal ☐ Right Temporal ☐ Parietal ☐ Sinus

Quality ☐ Dull ☐ Sharp ☐ Throbbing ☐ Stabbing ☐ Aura ☐ No Aura

Types ☐ Hat Band ☐ Cluster ☐ Migraine ☐ Tension

Employment – Occupation/Job Title _____ Work # _____ hours per day

Conditions Effect on Job Performance No Effect Mild Pain Moderate Pain Unable to Preform

Daily Activities – Effects of Current Condition on Performance

Bending	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Change Position (Sit-Stand)	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Climb Stairs	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Driving	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Extended Computer Use	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Household Chores	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Lifting	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Reading/Concentration	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Self-Care (Bathe/Dress)	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Sexual Activities	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Sleep	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Prolonged Sitting	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Prolonged Standing	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
Walking	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)

Recreational Activities – PLEASE LIST ANY CURRENT RECREATIONAL ACTIVITIES AND THE EFFECTS OF CURRENT CONDITION ON PERFORMANCE

_____	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)
_____	☐ No Effect	☐ Mild (Can do)	☐ Moderate (Limited)	☐ Severe (Unable to Perform)

LIFESTYLE REVIEW

1. On a scale of Poor, Good, Excellent please describe your lifestyle MARK **POOR, GOOD,** OR **EXCELLENT.**
   Diet _____ Exercise _____ Sleep _____ General Health _____
2. What Wellness service/products do you currently incorporate into your lifestyle? _____
   _____
3. What Supplements are you currently taking? _____
4. On a scale of 1-10 describe your stress level **1 = NONE / 10 = EXTREME** Occupational _____ Personal _____
5. **What are your top two health goals? 1.** _____ 2. _____ or ☐ **I do not have any**

An evaluation will be preformed which may include spinal and physical exams, orthopedic and neurological testing, palpation, specialized instrumentation and radiological examination (x-rays).

These statements made on this form are accurate to the best of my recollection and I knowingly allow NJ Spine & Wellness to examine me for further evaluation/treatment, and understand that I am responsible for all charges incurred.

Signature _____ **Date** _____ /_____ /_____

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THANK YOU FOR ALLOWING US TO SERVE YOU!

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Patient X-ray Waiver - Release and Indemnification Form

This form will confirm that the healthcare providers associated with NJ Spine and Wellness have recommended that I undergo spinal X-rays in connection with my evaluation and treatment or my condition. If you are pregnant, X-rays will not be taken.

In recognition of this voluntary waiver, I, as the undersigned patient, and for or on behalf of my minor child who may be subject to treatment hereby release and forever discharge and hold harmless; on behalf of myself, my heirs, representatives, executors, administrators, and assigns NJ Spine and Wellness, including its owners, officers, agents, contractors, assigns, employees, and legal representatives, from any and all responsibility, liability, causes of action, claim, or demand, or any nature whatsoever, including, but not limited to, a claim of **negligence** that may arise out of or relate in any manner to the evaluation of my present condition or resulting medical care which my healthcare provider may be unable to fully or properly analyze without the benefit of taking my X-rays. This release is to be broadly interpreted to extend to consequential property damage, and personal injury, including death. As such, I specifically give and authorize consent to the healthcare providers from NJ Spine and Wellness to administer treatment for treatment my condition, without the benefit of submitting to such X-rays.

I further agree to indemnify and hold harmless NJ Spine and Wellness, its owners, officers, contractors, agents, employees and assigns, from any and all causes of action, claims, demands, loss of any nature whatsoever arising out of or in any way related to the evaluation and treatment of my condition without submitting to having X-rays taken.

I hereby certify and attest that this release/waiver and agreement to indemnify and hold harmless is given freely, knowingly, and voluntarily. I further understand and acknowledge that by signing this form, I am signing a **legally binding agreement** which I may be waiving certain legal rights to recover compensation or obtain other remedies for injury to property and myself, including death, which I may have in the event that such injury or complication should occur as a proximate result of this waiver of my submission to X-rays, now or at any time in the future. I chose to sign this waiver fully knowing that my health may be jeopardized due to this decision.

Date:_____ _____
(Patient)

Consent of Treatment of a Minor

I hereby authorize NJ Spine and Wellness, together with whomever my treating healthcare provider may designate as an appropriate individual(s) to administer medical care, including X-rays, and appropriate adjunctive services as my treating healthcare provider deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

Date:_____ Patient (child/ward) _____

_____
Parent/Legal Guardian Signature

Acknowledgment of Non-Pregnancy Status

I hereby expressly acknowledge that I am not pregnant at the present time and that the healthcare providers from NJ Spine and Wellness are hereby expressly authorized and directed to complete a radiographic examination (X-rays) in connection with my treatment.

Date: _____ _____
Patient