SPINE & BALANCE CENTER OF NJ, LLC
Karl W. Nixdorf DC. PC
179 Cedar Lane Suite B
Teaneck, NJ 07666

Chiropractic Case History

Name_____Sex M F Date: _____

Address_____City_____State_____Zip_____

C. Phone(_____)_____H. Phone_____ Date of Birth_____ Age_____

Referred by_____Social Security #_____

Occupation_____ Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when?_____

1. Primary reasons for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

2. Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint: _____

_____

_____

4. Past Health History:

A. Previous illnesses you've had in your life: _____

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____

Females: What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Associated health problems of relatives: _____

_____

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

6. Social and Occupational History:

A. Level of Education:

O high school O some college O college graduate O post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctors Signature _____ Date _____

Spine and Balance Center of N.J., LLC
179 Cedar Lane Suite B
Teaneck, NJ 076663
Tel 201-907-5092
Fax 201-596-3630

Authorization for Health Information Disclosure

This form complies with HIPAA Privacy Rule

Date: _____

Patient Name: _____

Patient Address: _____City: _____ST:_____Zip:_____

I hereby authorize: _____
Name of physician's office/medical practice disclosing information

Requestor/Recipient Information

Spine and Balance Center of N.J., LLC
179 Cedar Lane Suite F
Teaneck, NJ 07666

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire in six months or on the following date: _____.**

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

_____ _____
Signature of Patient or Authorized Representative (if applicable) Date

_____ _____
Description of Representative's Authority (witness signature required) Signature of Witness