CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

James Gaeta D.C.
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800 Jessup Road. Suite 803A, Thorofare NJ 08086
phone: 856-983-8889
fax: 856-983-2229
www.drjamesgaeta.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name | Your Social Security Number | Birth Date (MM/DD/YYYY) | Age

Your First Name | Your Middle Name (or Initial) | Gender ○ Male ○ Female | Race

Address | Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated | Ethnicity

City | State/Province | ZIP/Postal Code | Preferred Language

Home Phone | Cell Phone | Spouse's Name

Email Address | Child's Name and Age

Emergency Contact | Emergency Contact's Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer | Work Phone

Address | May we contact you at work? ○ Yes ○ No

City | State/Province | ZIP/Postal Code | Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier | Policy Number

Insured's Last Name | Birth Date (MM/DD/YYYY) | Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name | Insured's Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

Patient name ______

Patient Number (office use only)

1. **The symptom(s) that have prompted me to seek care today include:** ______

2. **And are the result of (darken circle):** ○ An accident or injury
   ○ Work ○ Auto ○ Other ______
   ○ A worsening long-term problem
   ○ An interest in: ○ Wellness ○ Other ______

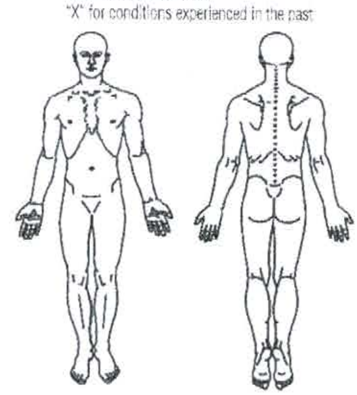
3. **Onset** (When did you first notice your current symptoms?) ______

4. **Intensity** (How extreme are your current symptoms?)
0 ○-○-○-○-○-○-○-○-○-○-○ 10
Absent Uncomfortable Agonizing

5. **Duration and Timing** (When did it start and how often do you feel it?)
○ Constant ○ Comes and goes. How Often? ______

6. **Quality of symptoms** (What does it feel like?)
- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other ______

7. **Location** (Where does it hurt?) Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



8. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) ______

9. **Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? ______
What tends to lessen the problem? ______

10. **Prior interventions** (What have you done to relieve the symptoms?)
○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other ______
○ Physical therapy ○ Massage ______

11. **What else should Dr. Gaeta know about your current condition?** ______

12. **How does your current condition interfere with your:**

Work or career: ______

Recreational activities: ______

Household responsibilities: ______

Personal relationships: ______

Consultation Notes

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness	NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising	NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia	NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ____

______
Doctor's Initials

James Gaeta D.C.

(Continued from previous page)

h. Endocrine

Had Have ○ ○ Thyroid issues | ○ ○ Immune disorders | ○ ○ Hypoglycemia | ○ ○ Frequent infection | ○ ○ Swollen glands | ○ ○ Low energy | NONE ○ Initials ____

i. Genitourinary

Had Have ○ ○ Kidney stones | ○ ○ Infertility | ○ ○ Bedwetting | ○ ○ Prostate issues | ○ ○ Erectile dysfunction | ○ ○ PMS symptoms | NONE ○ Initials ____

j. Constitutional

Had Have ○ ○ Fainting | ○ ○ Low libido | ○ ○ Poor appetite | ○ ○ Fatigue | ○ ○ Sudden weight gain/loss (circle one) | ○ ○ Weakness | NONE ○ Initials ____

Patient name

Patient Number (office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	Illness	Had	Have	Illness
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	Treatment
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____

○	○	Medications (prescription and over-the-counter):

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Dr. Gaeta about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
____		○	○			○	○

19. Are there any other hereditary health issues that you know about? ____

20. Social History

Tell Dr. Gaeta about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much?____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much?____			
Hobbies: ____						

Doctor's Initials

James Gaeta D.C.

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? ____________ **23. How much sleep do you average per night?** ______ **Hours**

24. What is the type and approximate age of your mattress and pillow? ______ **25. What is your preferred sleeping position?** ______

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ____________

28. In addition to the main reason for your visit today, what additional health goals do you have? ____________

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** ____________

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: ____________

Signature ____________ Date (MM/DD/YYYY) ____________

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

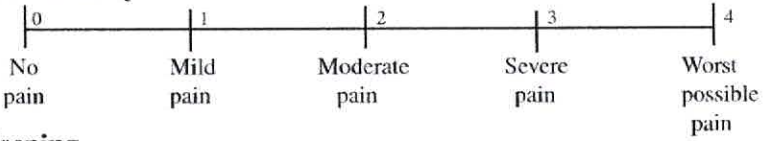
James Gaeta D.C.

Functional Rating Index

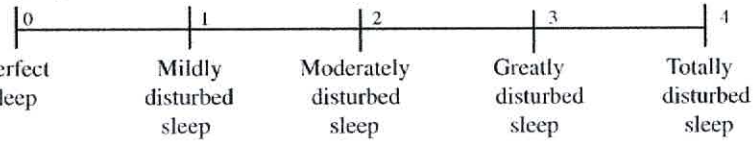
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

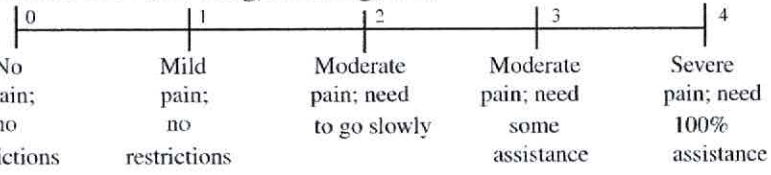
1. Pain Intensity



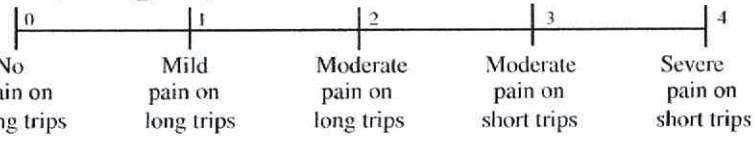
2. Sleeping



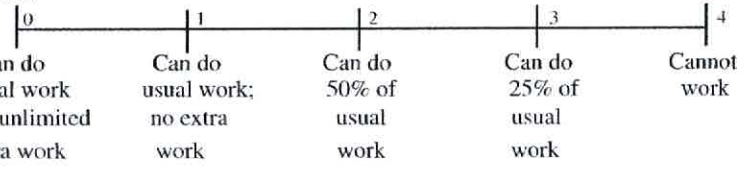
3. Personal Care (washing, dressing, etc.)



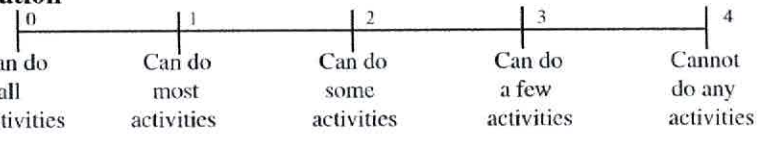
4. Travel (driving, etc.)



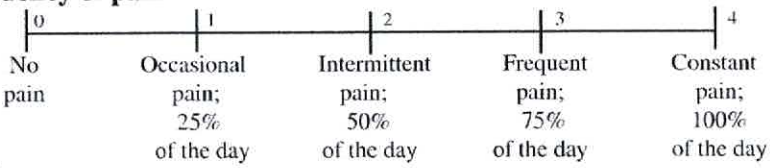
5. Work



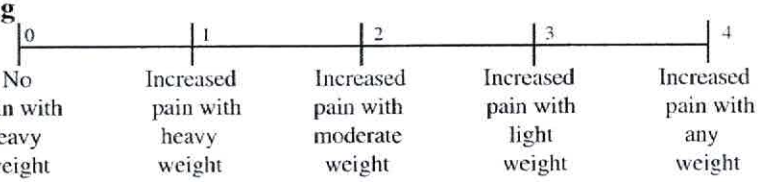
6. Recreation



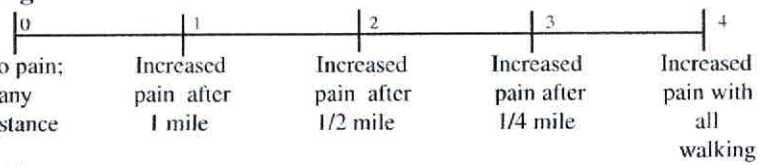
7. Frequency of pain



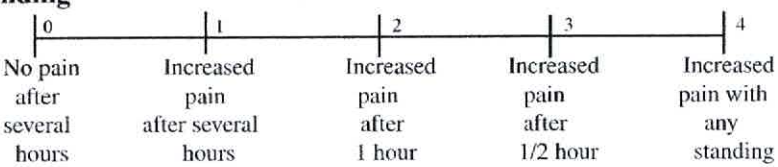
8. Lifting



9. Walking



10. Standing



Total Score _____

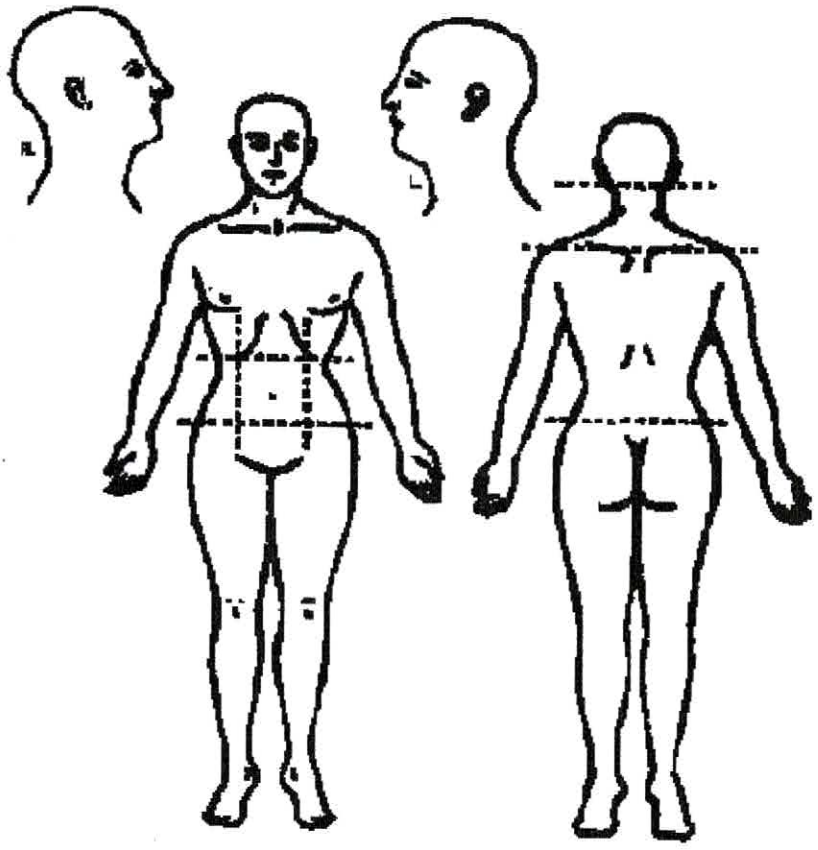
Name _____
PRINTED

_____
Signature

_____
Date

Where is your pain now? Mark the areas where you feel sensations using the appropriate symbols. Please mark an X on the area where the pain is now worst.

Aching	Numbness	Pins and Needles	Burning	Sharp/stabbing	Stiff/tight
yyyyy	= = =	oooo	zzzz	/////	***



How bad is your pain? On the scale below circle your pain.

Right now..... No pain 0 1 2 3 4 Worst possible pain
On average..... No pain 0 1 2 3 4 Worst possible pain
At its very worst... No pain 0 1 2 3 4 Worst possible pain

Overall, is your pain generally: improving ❒ same ❒ worsening ❒

Name _____ Date_____

form 102