BLOOMFIELD
WELLNESS CENTER

1000 Broad Street | Bloomfield, NJ 07003 | Tel: 973-259-1919 | Fax: 973-259-1936

Date: _____

Name: _____ **Birthdate:** _____

Address: _____**Town:** _____ **State:** _____ **Zip:** _____

Home #:_____ **Work #:**_____ **Cell #:**_____

Male: _____ **Female:** _____ **E-mail:**_____

Occupation/Employer's Name & Address: _____

Single: _____ **Married:** _____ **Divorced:** _____ **Widowed:** _____

Spouse's Name: _____ **Employer:** _____ **DOB:** _____

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

Do you have medical insurance? Yes □ No □ **Insurance Company Name:** _____

Insured's Name (if different from patient): _____

Relationship to patient: _____

Insured's Date of Birth: _____

PATIENT HEALTH ASSESSMENT

1. **What is your present complaint?** _____

_____

2. **How would you describe your pain?**

□ Sharp	□ Soreness	□ Throbbing	□ Tingling
□ Dull	□ Stiffness	□ Spasm	□ Burning
□ Ache	□ Weakness	□ Numbness	□ Shooting

3. **How would you rate the intensity of your pain? (Please circle)**

4. **How often is the pain present?**

□ Constant (80 – 100%)	□ Frequent (50 – 80%)
□ Occasional (25 – 50%)	□ Intermittent (25% or less)

5. When did your problem begin? (Give approximate date if possible)_____

6. Since your problem began is the pain:

□ Getting worse □ Getting better □ Staying the same

7. How did your problem begin?

□ Auto accident □ Work related □ Other type of accident

□ Gradual □ Sudden □ No specific reason

8. Describe how the problem began: _____

_____

_____

9. What makes your problem better?

□ Nothing □ Walking □ Standing □ Sitting

□ Moving around/exercise □ Lying down □ Inactivity

10. What makes your problem worse?

□ Nothing □ Walking □ Standing □ Sitting

□ Moving around/exercise □ Lying down □ Inactivity

11. What prior treatments have you received for this present condition?

□ Medical □ Chiropractic □ Physical Therapy

□ Acupuncture □ Surgery □ Other _____

Did the treatments help? □ Yes □ No

12. Are you currently taking any medications? □ Yes □ No

13. List any major or minor surgery(s):_____

_____

14. What is your physical activity at work?

□ Mostly sitting □ Light manual labor

□ Moderate manual labor □ Heavy manual labor

15. What general physical activity do you do?

□ No regular exercise □ Light exercise □ Strenuous exercise

Describe _____

16. What is your present general stress level?

□ **No** stress □ Minimal stress □ Moderate stress □ greatly stressed

17. Is your problem affecting your ability to work or do other routine daily activities?

□ No effect

□ Need some assistance with daily activities

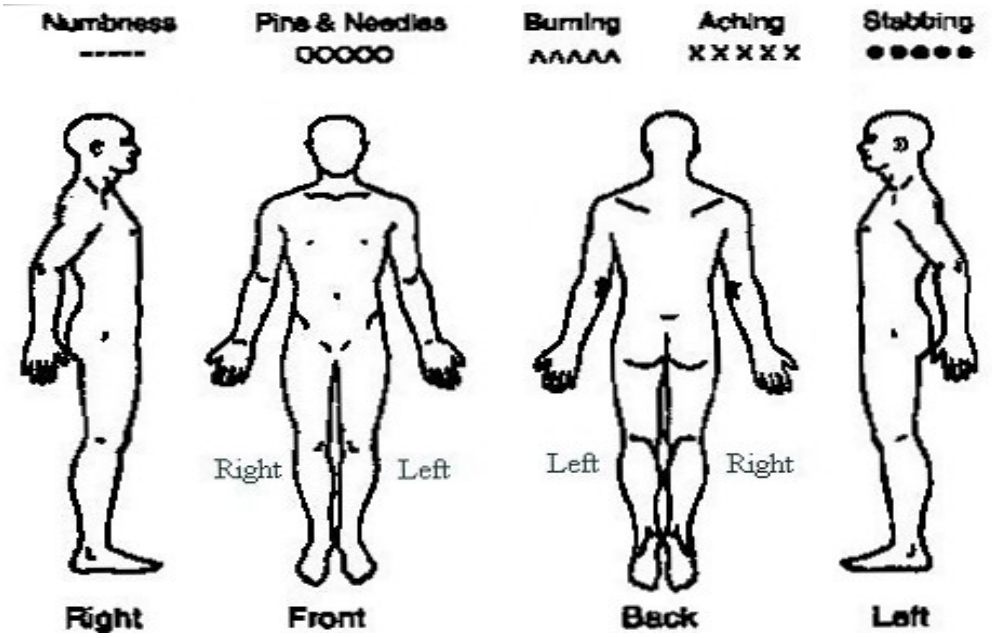
□ Cannot function without assistance

□ Have some limited physical restrictions, but can function

□ Cannot work

□ Totally disabled

Please mark an X on the figures below where you have pain, ache, numbness, or tingling.



Below is a listing of symptoms, conditions, or habits.
Please check the box indicating whether this applies to past or present.

Past	Present		Past	Present	
□	□	Neck pain	□	□	High blood pressure
□	□	Shoulder pain	□	□	Heart condition
□	□	Arm/elbow pain	□	□	Respiratory condition
□	□	Hand pain	□	□	Digestive problems
□	□	Upper back pain	□	□	Kidney/bladder problem
□	□	Lower back pain	□	□	Menstrual problems
□	□	Pain in upper leg or hip	□	□	Breast soreness/lump
□	□	Pain in lower leg or knee	□	□	Sinus conditions
□	□	Pain in ankle or foot	□	□	Allergies/asthma
□	□	Jaw pain	□	□	Cancer
□	□	Swelling/stiffness of joints	□	□	Stroke
□	□	Headaches	□	□	Excessive weight gain/loss
□	□	Dizziness	□	□	Skin condition
□	□	Fainting spells	□	□	Arthritis
□	□	Convulsions	□	□	Diabetes
□	□	General prolonged fatigue	□	□	Prostate condition
□	□	Condition of uterus/ovaries			

Past	Present		Occasional	Moderate	Heavy
□	□	Tobacco use	□	□	□
□	□	Alcohol use	□	□	□
□	□	Caffeine (coffee, tea, soda)	□	□	□
□	□	Pregnancy			

I do hereby authorize Bloomfield Wellness Center to administer such care that is necessary for my particular case. I further agree to pay for services rendered as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me, and that I am personally responsible for payment of any and all services non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature_____ **Date**_____