Highpoint Health Center

Welcome Packet

Life Changing Care

317 Cleveland Ave

Highland Park, New Jersey

(732)249-9800

Personal History:

Print Name_____ Today's Date_____

Male___ Female___ Date of Birth_____

Street Address_____

City_____ State_____ Zip_____

Business/Employer_____ Type of Work_____

Check One: Married____ Single____ Widowed____ Divorced____ Separated___

Number of Children____

Email(to receive free health newsletter)_____

H phone _____ W phone_____ C phone_____

Emergency Contact: Name _____

Phone_____ Relationship_____

Referred to this office by:_____

If your primary complaint is related to issues such as allergy, digestion, anxiety, weight loss, etc., please proceed to page 4.

If your primary complaint is **physical pain** in your neck, back or any joint, or headaches please describe your physical pain below- list all areas that cause you discomfort:

_____

_____

_____

Then, please proceed to page 3.

1. How did the problem begin: Accident☐ Trauma☐ Illness☐ Repetitive Motion☐ Unsure☐

   a. Describe how the problem began:

   _____

   _____

2. How would you describe the pain?

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

3. How would you rate the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10
[No Pain] [Moderate Pain] [Terrible/Unbearable Pain]

4. How often is the pain present:

   ☐Constant [81-100%] ☐Frequent [51-80%] ☐Occasional [26-50%] ☐Intermittent [25 or less]

5. When did you first notice the problem?

   _____

   _____

6. Since the problem began has there been a more recent flare-up? ☐Yes ☐No

   If so, when and what was the cause [If known]?

   _____

   _____

7. Since your problem began, is the pain:
   ☐Getting Worse ☐Getting Better ☐Staying the Same

8. What makes your problem better:

   ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Moving around/exercise
   ☐Lying down ☐Inactivity

9. What makes your problem worse:

   ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Moving around/exercise
   ☐Lying down ☐Inactivity

10. What daily activities make the problem better [B] or worse [W]?

	B	W		B	W		B	W		B	W
Sleeping	☐	☐	Bending Forward	☐	☐	Reaching overhead	☐	☐	Walking stairs	☐	☐
Getting dressed	☐	☐	Bending Backward	☐	☐	Lifting	☐	☐	Driving	☐	☐

Please proceed to page 5

When did your major symptoms begin & describe **how** they began:

_____

_____

_____

_____

Describe your major symptoms: _____

_____

_____

_____

I understand that my insurance may not pay for issues that are not related to the back and spine. In that case I am financially responsible for the services I receive.

_____ _____

Date Signature

Go to next page

1. **Please check the function status that follows which best describes your situation:**

☐ Minimal [Can forget problem with activity]
☐Slight [Activity requires infrequent breaks]
☐Moderate [Activity requires frequent breaks and modification of tasks]
☐Severe [Precluded from any or all activity except absolutely necessary]

2. **Which other physicians have you seen for this condition?**

Name:_____ Address:_____ Tel:_____

Name:_____ Address:_____ Tel:_____

3. **Medications you now take and the purpose for taking them [to the best of your knowledge]**

_____

_____

_____

4. **Past Health History**

Please describe if applicable:

Major surgery/Operations: _____

Broken Bones/Fractures: _____

Other: _____

Major Accidents or falls [Please include dates and treatment]:_____

_____

Hospitalization [other than above] [Please include dates and treatment]:_____

_____

Previous Chiropractic care [Please include approximate date of last visit]:_____

_____

5. **BELOW IS A LIST OF CONDITIONS, WHICH MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE QUESTIONS MUST BE ANSWERED CAREFULLY AS THESE PROBLEMS CAN AFFECT YOUR OVERALL DIAGNOSIS, TREATMENT PLAN AND POSSIBILITY OF BEING ACCEPTED FOR CARE.**

☐ Alcoholism	☐ Cancer	☐ Eczema	☐ Influenza	☐ Mental Disorder	☐ Polio
☐ Anemia	☐ Chicken Pox	☐ Epilepsy	☐ Lumbago	☐ Mumps	☐ Rheumatic Fever
☐ Appendicitis	☐ Diabetes	☐ Goiter	☐ Malaria	☐Pleurisy	☐ Scarlet Fever
☐ Arthritis	☐ Diphtheria	☐ Heart Disease	☐ Measles	☐Pneumonia	☐ Small Pox
☐ Tuberculosis	☐ Thyroid Fever		☐Venereal Infection	☐Whooping Cough	

Metabolic Assessment Form

PART I: Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal sweating	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hrs after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hrs after eating	0	1	2	3
Pain tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hrs after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you ever had your gallbladder removed?	Yes			No

Category VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3

Category IX (continued)

Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category X

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hrs of sleep	0	1	2	3
Excessive perspiration or perspiration with little/no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alternation in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp				
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV(continued)

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars w/o symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" – type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased # of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No			
Alternating menstrual cycle lengths	Yes	No			
Extended menstrual cycle (<32 days)	Yes	No			
Shortened menstrual cycle (>24 days)	Yes	No			
Pain and cramping during periods		0	1	2	3
Scanty blood flow		0	1	2	3
Heavy blood flow		0	1	2	3
Breast pain and swelling during menses		0	1	2	3
Pelvi pain during menses		0	1	2	3
Irritable and depressed during menses		0	1	2	3
Acne		0	1	2	3
Facial hair growth		0	1	2	3
Hair loss/thinning		0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal? _____years

Since menopause, do you ever have uterine bleeding?	Yes				No
Hot flashes	0	1	2	3	
Mental fogginess	0	1	2	3	
Disinterest in sex	0	1	2	3	
Mood swings	0	1	2	3	
Depression	0	1	2	3	
Painful intercourse	0	1	2	3	
Shrinking breasts	0	1	2	3	
Facial hair growth	0	1	2	3	
Acne	0	1	2	3	
Increased vaginal pain, dryness, or itching	0	1	2	3	

If you have had health problems for more than 3 months, please complete this page.

1. How have you taken care of your health in the past?
   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify): _____
2. How did the previous method(s) work out for you?
   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying
   h. Confused
3. How have others been affected by your health condition?
   a. No one is affected
   b. Haven't noticed any problems
   c. They tell me to do something
   d. People avoid me
4. What are you afraid this might be (or beginning) to affect (or will affect)?
   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom
5. Are there health conditions you are afraid this might turn into?
   a. Family health problems
   b. Heart disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic fatigue
   i. Need surgery

How has your health condition affected your job, relationships, finances, family or other activities? _____

_____

What has this condition cost you in time, money, happiness, freedom, sleep, promotion, etc.

_____

What are you most concerned with regarding your problem? _____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

_____

What would be different/better without this problem? _____

_____

What percentage of improvement would you have to get to change your life? _____

How important is resolving your condition to you? [1-10] _____

HIPAA PRIVACY NOTICE

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND REPORT ANY GRIEVANCE.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the Patient, significant new rights to understand and control how your health information is being used. HIPAA provides penalties for covered entities that misuse personal health information.

We have prepared this "Summary Notice of PIPPA Privacy Practices" to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A notice of HIPAA Privacy Practices containing a more complete description of the uses and disclosures of your health information are available to you upon request.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations:

TREATMENT means providing, coordination, or managing health care and related services by one or more health providers.
PAYMENT means such activities as obtaining reimbursement for services, billing, or collection activities and utilization review.
HEALTH CARE OPERATIONS include the business aspects of running our laboratory service practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide laboratory draw site information or other health-related services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request:

1. You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment, and health care operations. You may also request that we limit our disclosures to persons assisting your care. We will consider your request, but are not required to accept it.
2. You have the right to request that you received communications containing your protected health information from us by alternative means or at alternate locations. For example, you may ask that we only contact you at home or by mail.
3. Except under certain circumstances, you have the right to inspect and copy medical, billing, and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.

4. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.
5. You have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment before April 23, 2003 among others. If you ask for this information from us more than once every twelve months, we may charge you a fee.

Highpoint Health Center

317 Cleveland Ave

Highland Park, NJ 08904

(732) 249-9800

Acknowledgement

I acknowledge receipt of the **HIPAA Privacy Notice** by signing and dating below.

_____ _____

Signature Date

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although it may have an effect on a disease process or symptom, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive nutritional schedule is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the psychological and biomechanical processes of the human body. Nutritional advice may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above.

Signature

_____ Date_____

I also understand that Dr. Harry Schick is a chiropractor and he works to help the body be in the best possible health. Under no circumstances does he treat any disease or promote cures for any medical condition.

Signature

_____ Date_____