317 Cleveland Avenue
Highland Park, NJ 08904
Phone: 732.249.9800 Fax: 732.249.6300

Name: _____ Date: _____

Date Of Birth: _____ Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

E-Mail: _____ Occupation: _____

Marital status (check one) ☐ Married ☐ single ☐ Widowed ☐ Divorce ☐ Separated

Number of Children (if any): _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Referred to this office by: _____

1. Describe your major symptoms:

   _____

   _____

   _____

2. Describe when and how your major symptoms began:

   _____

   _____

   _____

Past medical History:

Please describe if applicable:

Major surgery: _____

Broken bones/ Fracture: _____

Major accidents or falls *[Please provide dates if possible]* _____

Hospitalization: _____

Previous Chiropractic care: _____

Please list any medication and the purpose of taking them:

_____

_____

_____

Which other physicians have you seen for this same condition?

Name: _____ Address: _____ Telephone: _____

Name: _____ Address: _____ Telephone: _____

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II 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 swelling	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 hours 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 hours 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

Category VI (continued)				
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 hours 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 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
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

Copyright © 2015, Great Smokies, All Rights Reserved.

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

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 hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or 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
Alteration 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 amounts 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	0	1	2	3
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
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 without 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 or dribbling	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 number 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 (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 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
Pelvic 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

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Copyright © 2012, Paleo Chemistry. All Rights Reserved.

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 MAY 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	☐ Smallpox
☐ Tuberculosis	☐ Thyroid Fever	☐ Venereal Infection	☐ Whooping Cough		

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. Medication
   - 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. Chronic Fatigue
   - 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, relationship, 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? _____

_____

What 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 a problem?

_____

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

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

_____

If you **also have** physical pain in your neck, back or any joint, or if you experience frequent aches, please describe your physical pain below. (List areas that cause you discomfort.)

_____

_____

_____

Please check the function status that best describes your situation:

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

1. When did you notice your pain? _____
2. Cause of pain: ☐ Accident ☐ Trauma ☐ Illness ☐ Repetitive ☐ Motion ☐ Unsure
   - Describe how the problem began:

     _____

     _____
3. Intensity of your pain:

   0 1 2 3 4 5 6 7 8 9 10

   [No Pain] *[Moderate Pain]* *[Terrible/Unbearable Pain]*
4. How would you describe your pain:

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

5. How often is the pain present:

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

6. Since the problem began, has there been a more recent flare-up? ☐ Yes ☐ No
If so, when and what was the cause_____
_____
_____

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
☐ Laying down ☐ Inactivity ☐ Moving around/exercise

9. What makes your problem worse:

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

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

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

Please fill out current insurance information:

Insurance Carrier: _____ ID Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship: ☐ Self ☐Parent ☐Spouse ☐Child ☐ Other: _____

Secondary Insurance: _____ ID Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship: ☐ Self ☐Parent ☐Spouse ☐Child ☐ Other: _____

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 HIPAA 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 use and disclosure 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 management of 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 conduction quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and dispute 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 disclosure 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 way we use and disclose your health information for treatment, payment, and health care operations. You may also request that we limit our disclosure 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 receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.
3. Except under certain circumstances, you may 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 on 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 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.

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

_____ _____

Signature Date

OTH

High Point Health Center

317 Cleveland Avenue
Highland Park, NJ 08904
Phone: 732.249.9800 Fax: 732.249.6300

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 adjective 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 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.

I have read and understand the above.

Signature: _____ Date: _____

OTH

317 Cleveland Avenue
Highland Park, NJ 08904
Phone: 732.249.9800 Fax: 732.249.6300

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY**: I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service. Co-payments are due at time of service. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**: I hereby authorize and direct payment of my medical benefits to *HIGHPOINT HEALTH CENTER* on my behalf for any services furnished to me by the providers.

3. **AUTHORIZATION TO RELEASE RECORDS**: I hereby authorize *HIGHPOINT HEALTH CENTER* to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

4. **MEDICARE REQUEST FOR PAYMENT:** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in *HIGHPOINT HEALTH CENTER*. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party — Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party — Relationship to Patient

317 Cleveland Avenue
Highland Park, NJ 08904
Phone: 732.249.9800 Fax: 732.249.6300

Minor Consent Form

Patients Name: _____ DOB: _____

Legal Guardian: _____ Date: _____

I _____, legal guardian of _____; herby authorize **Dr. Harry B Schick** to administer reasonable and standard evaluations, techniques, manipulations and treatments to my son or daughter ***WHO IS UNDER THE AGE OF EIGHTEEN YEARS*** and who will receive treatment rendered at **High Point Health Center**. This professional care will be necessary to successfully treat any injuries or ailments the patient may have. In the event of an emergency, and since the patient is a minor, I hereby give my permission and consent to **High Point Health Center** to administer care as needed and not hold **High Point Health Center** harmless in their act of good faith.

Further, as parent or legal guardian, I am responsible for the health care decisions of my minor child and agree that my insurance plan is primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child

Patient Name (Print): _____

Parent/Legal Guardian Name (print): _____

Parent/Legal Guardian Signature: _____ Date:_____

R/S 05/05/2022