BAREFOOT
REHABILITATION CLINIC
SPORTS THERAPY &
CHRONIC PAIN RESOLUTION

5 Eastmans Rd, Parsippany, NJ 07054
Phone: 862 - 205 - 4847 (HUGS)
Email: scheduling@barefootrehab.com
www.barefootrehab.com

Date: _____/_____/_____Patient's Full Name: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐Male ☐Female Age: _____ Date of Birth: _____/_____/_____Social Security #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

How would you like to be addressed by our staff? _____

☐Married ☐Single ☐Widowed ☐Separated ☐Divorced Number of Children: _____Ages: _____

Occupation: _____Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ City: _____ State: _____ Zip: _____

Family Physician: _____Address: _____

City: _____ State: _____ Zip: _____Phone:_____

**May our office inform your physician of our exam findings, diagnosis, and treatment plan? ☐Yes ☐No

Whom may we thank for referring you? _____

ATTENTION: *Please fill out all information. We cannot begin the consultation until this form is completed fully.*

CHIEF COMPLAINT

(No, you can't just say your "husband" or "wife")

Chief complaint: _____

Secondary or related complaint(s) if any: _____

When did this bout **begin**? _____ Was the **Onset**: ☐Gradual ☐Sudden

Since the onset, has it gotten: ☐Worse ☐Stayed same ☐Better

Has this occurred before: ☐Yes ☐No How long ago since first occurrence? ____ months / years ago

What **caused** the pain: ☐no apparent cause ☐one incident _____

What makes the pain **worse**? _____

How long do you have to do the above activity before you experience symptoms? _____

How **intense** is the pain: ☐Minimal ☐Mild ☐Moderate ☐Severe/Excruciating

Have you had any changes in bowel or bladder functioning? ☐Yes ☐No

Have you been treated for your present problem in the past? ☐Yes ☐No

If yes, when: _____If yes, by whom: _____

Outcome: ☐No effect ☐Somewhat better ☐Resolved

What does your condition prevent you from normally doing? ☐sitting/driving ☐walking ☐running ☐golfing ☐swimming ☐weight lifting ☐work ☐playing with children ☐sleeping ☐normal activities of daily living ☐other: _____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

_____

Do you want this pain gone? ☐Just now ☐Forever

Is there anything else I should know? _____

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Describe the **quality** of the complaint/pain:

- ☐ sharp/ stabbing
- ☐ dull/ache
- ☐ pulling/tight
- ☐ tingling/numbness
- ☐ burning/throbbing
- ☐ other: _____

Describe the **location** of the symptoms:

- ☐ generalized dull, deep ache
- ☐ pin point
- ☐ pain starts localized, but then radiates
  Describe: _____
- ☐ other: _____

The symptoms are:

- ☐ more prevalent in the morning
- ☐ more prevalent at night
- ☐ better as the day goes on
- ☐ worse as the day goes on

How often daily are you aware of the symptoms:

- ☐ intermittent (less than 25% of time)
- ☐ occasional (25-50% of time)
- ☐ frequent (50-75% of time)
- ☐ constant (75-100% of time)

Does any of the following make the **pain worse**:

- ☐ lifting/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ bending forward/leaning back
- ☐ other:_____

Does any of the following make the **pain better**:

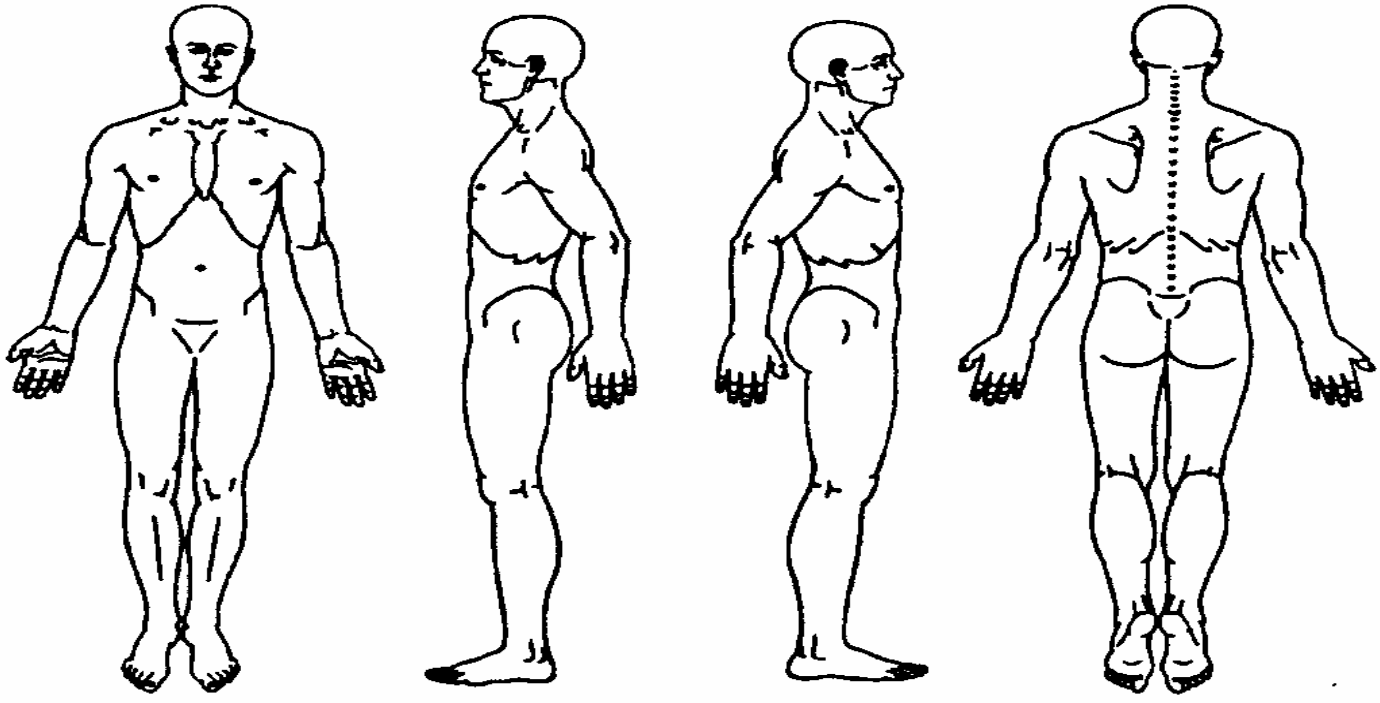
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ standing
- ☐ other:_____
- ☐ ice
- ☐ heat
- ☐ aspirin

The symptoms feel:

- ☐ better with exercise/activity
- ☐ worse with exercise/activity
- ☐ no change with exercise/activity

Does it interfere with your daily activities:

- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)



Pain Scale

0 1 2 3 4 5 6 7 8 9 10

←----------→

No pain Moderate Severe

Please Circle Current Level of Pain

Use the following letters to indicate the type and location of discomfort:

A - Aching
B - Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

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LIFESTYLE

What **medications** are you currently taking? _____

What **vitamins/supplements** are you currently taking? _____

How many night per week do you drink **alcohol**? _____ On those nights, how many drinks do you have?_____

Do you smoke **cigarettes**? ☐Yes ☐No How much **mental stress** do you experience? ☐Mild ☐Moderate ☐Severe

How many hours of **sleep** do you get/night? _____ What time do you go to bed? _____

Do you eat the following with every meal?

Vegetables: ☐Always ☐Sometimes ☐Never **Animal Protein**: ☐Always ☐Sometimes ☐Never

What did you have for **breakfast**? _____

What **general physical** activity do you do? ☐ No regular exercise ☐ Light exercise ☐Strenuous exercise

What type of physical activity do you do? ☐ Cardiovascular ☐ Resistance ☐ Walking ☐Other _____

What is your **athletic history** (middle, high school, college, post-college)? _____

Females only: Are you currently pregnant? ☐Yes ☐No

In general, would you say your health is (check one): ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

PAST HEALTH HISTORY

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem: _____

What treatment(s) were received: _____Were they helpful? ☐Yes ☐No

Doctor's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries.

Date	Injury/Fracture/Illness/Surgeries/Falls	Treatment	Results

Please indicate any of the following illnesses you have had or currently have with approximate dates.

High Blood Pressure_____ Prostate disease_____ Multiple Sclerosis_____

Heart disease_____ Ulcer_____ Headaches_____

Stroke_____ Allergies_____ Cancer_____

Diabetes_____ Scoliosis_____ Seizures_____

Kidney disease_____ Mental/Emotional_____ Auto accident_____

Fevers _____ Upset stomach _____Other_____

Signature of Patient: _____***Date***:_____

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HIPPA NOTICE OF PRIVACY PRACTICES

YOUR HEALTH INFORMATION RIGHTS:

Unless otherwise required by law, your record is the physical property of the healthcare practitioner or facility that compiled it, but the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health records. You may also request a copy of your medical records at any time. This organization is required to maintain the privacy of your health information.

By signing this document, I **(PRINT NAME)** _____, acknowledge that I waive my right to privacy regarding the below individuals.

In order to give you the best care possible, we've found it helpful to connect with and send reports to other individuals close to you or healthcare providers who are serving you.

**I want you to send a report of my condition to the following people/providers: ☐Yes ☐No

I authorize my care/condition to be discussed with the following:

Name	Relationship	Phone Number
Physician's Name	Field	Phone Number
Physician's Name	Field	Phone Number

Patient/Guardian Name Printed	**Patient/Guardian Signature**	**Date**
Witness Name Printed	Witness Signature	Date

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BILLING POLICIES AND PATIENT RESPONSIBILITY

Dear Patient:

We will attempt to provide you with information necessary to determine the type of care you will require and the financial information you may need to determine how you wish to handle your financial obligation to our office.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian. **It is our policy to collect the below fees at the time of service**. However, Barefoot Rehabilitation Clinic does accept insurance plans that have *out-of-network* benefits. Should your insurance company cover any of your care, you will be refunded based on how much they cover.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended.

Our office fees are **$145** for an initial exam and **$75** for subsequent visits.

Our office fee for Heroes Journey Crossfit members and referrals is **$125** for an initial exam and **$65** for subsequent visits.

If you are unable to keep an appointment, please give 24-hours notice. We don't want to charge you for missed appointments, but it is an inconvenience because that time block could have been booked by someone else. In return, we ask that you ...

- Get us a book off of our Amazon Wishlist.
- Prepare us a "paleo" meal.
- Buy us flowers (or just give us a hug, a smile, and say "I'm sorry.").

I have elected to use the following payment method to finance my care at the Barefoot Rehabilitation Clinic. NOTE: The Barefoot Rehabilitation Clinic will refund any overpayments made to us upon completion of care.

___1. CASH – Payment is due at the time of service.

___2. PERSONAL CHECK – Payment is due at the time of service.

___3. CREDIT CARD – Payment is due at the time of service.

PATIENT'S SIGNATURE:_____**Date**:_____
WITNESS:_____

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INFORMED CONSENT

Health care professionals are required to obtain your informed consent prior to treatment. Informed consent is the patient's legal right to know all the risks and benefits inherent to a medical procedure prior to agreeing to treatment.

I **(PRINT NAME)** _____, do hereby give my consent to have chiropractic care procedures performed. I understand that the procedures may consist of chiropractic manipulations/adjustments involving joints and soft tissues. I acknowledge that all health care procedures have some risks and complications, and that chiropractic spinal and extremity manipulations/adjustments have some limited, inherent risks that seldom occur. I have considered the following risks and complications regarding chiropractic care:

- **Soreness/Bruising**: It is common to experience localized muscle soreness and occasionally minor bruising in the treatment area.
- **Fractures**: In isolated cases, fractures may result from treatment.
- **Stroke**: Although there has never been a direct link between chiropractic manipulation/adjustment and stroke, I am aware that stroke is reported to occur once in one million to once in ten million treatments.

I also understand that the beneficial effects associated with these procedures including decreased pain, improved mobility and function, and increased quality of life. Reasonable alternatives have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises, and surgery.

By signing below, I now voluntarily and freely agree to have the chiropractic care procedures recommended and performed. I have had the opportunity to ask questions regarding the above information and possible consequences and risks. I have no further questions and I acknowledge that no guarantee of cure has been made to me concerning results and treatment.

Signature of Patient _____

Signature of Parent or Guardian (if a minor) _____Date_____

Signature of Witness _____ Date _____