

Barefoot Rehabilitation Clinic

50 Bank St, Morristown, NJ 07960

Phone: 201-919-4329

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

Payment Method: Cash Check Credit

Whom may we thank for referring you? _____

CHIEF COMPLAINT

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

Chief complaint: _____

Secondary or related complaint(s) if any: _____

Was the **Onset**: Gradual Sudden

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

When did this bout **begin**? _____

Has this occurred before: Yes No

How long ago since first occurrence? ____ (please circle) months / years ago

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

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**:

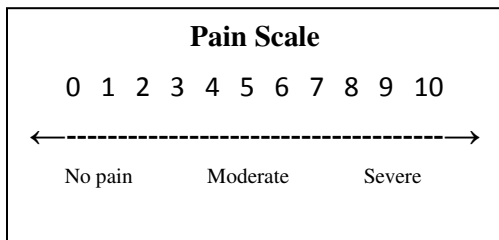
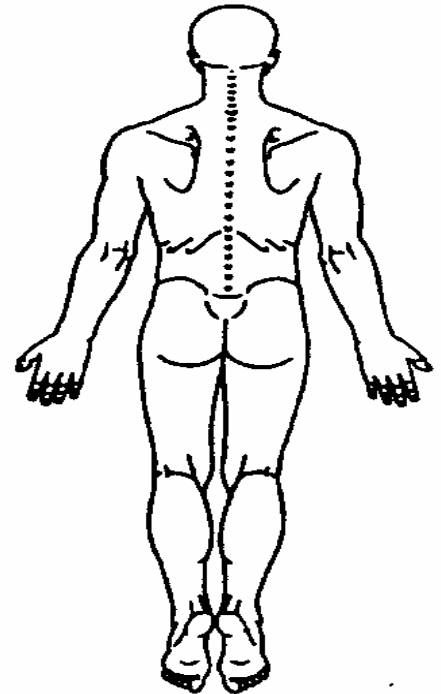
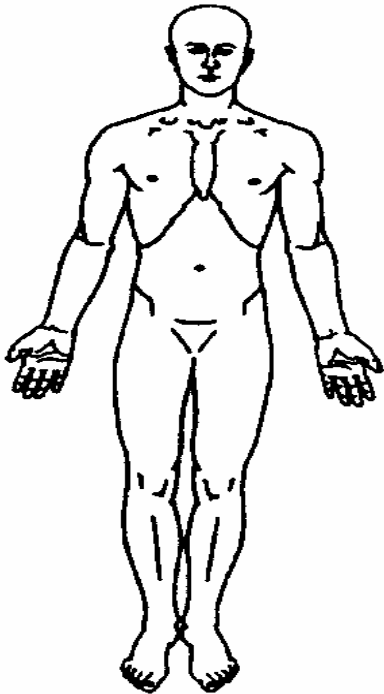
- rest/laying down
- sitting
- walking/exercise
- standing
- other: _____
- ice
- heat
- aspirin

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)



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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STRESSORS

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

Do you eat **vegetables** with every meal? Always Sometimes Never

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 _____

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 daily sign-in sheet for purposes of proof of attendance.

| | | |
|--------------------------------------|-----------------------------------|-------------|
| _____ | _____ | _____ |
| Patient/Guardian Name Printed | Patient/Guardian Signature | Date |
| _____ | _____ | _____ |
| Witness Name Printed | Witness Signature | Date |

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

| | | |
|-------|--------------|--------------|
| _____ | _____ | _____ |
| Name | Phone Number | Relationship |
| _____ | _____ | _____ |
| Name | Phone Number | Relationship |
| _____ | _____ | _____ |
| Name | Phone Number | Relationship |

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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 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: _____