PARAMUS
MEDICAL & SPORTS REHABILITATION CENTER

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name ______________________ Sex ______________ Date __________

Address ____

Date of Birth ____________________ Place of Birth ____________________

Telephone: Home (_____)__________ Work (_____)________ Fax (____)__________

Occupation __________________ Marital Status ________ Ht _____ Wt _____

Social Security # ____

Have you ever received Oriental Medical Treatments before? ______________________

Referred By ____

Chief Complaint ____

Medical History of Chief Complaint: Date of Onset ______________________

Have you ever experienced this before? ______________________________

List any previous treatments for this condition including any hospitalizations, surgeries, medications, physical therapy, exams, lab tests (blood analysis, X-Ray, MRI, etc.). ______________________

____

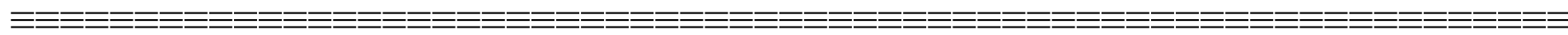
Does this condition interfere with your daily activities (work, exercise, sleep, sex, etc.)? __________

____

Medical doctor's name, address & phone number: ______________________

____

Date of last visit & diagnosis: ______________________________



Family History

Illness	Father	Mother	Siblings	Spouse	Children
Cancer					
Diabetes					
High Blood Pressure/Heart Disease					
Allergies					
Drug Abuse					
Mental Illness					
Other					

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Lifestyle Habits

Please state below how much, how many, or how often.

Cigarettes (packs) ___________ Coffee/Tea (cups) ________________ Alcohol (type – per week) _________________

Drugs: Prescription ____

Over-the-Counter ____ Recreational ________________________________

Vitamins &/or Herbs ____

Dietary Restrictions ____

Food Cravings ____

Exercise (type) ____

Other Regular Activities (reading, TV, meditation, etc.) ____

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Please check any of the symptoms experienced in the last 3 months.

	Often	Seldom	Severe	Mild		Often	Seldom	Severe	Mild
General					**Nose/Throat/Mouth**				
Insomnia					Nosebleeds				
Dreams					Sinus Infection				
Irritability					Dry Nose				
Depression					Nasal Congestion				
Mood Swings					Sore Throat				
Fatigue					Loss of Voice				
Poor Memory					Difficulty Swallowing				
Fever					Mouth Sores				
Chills					Bleeding Gums				
Weight Loss					Dry Mouth				
Weight Gain					Thirst				
Head & Neck					**Eyes**				
Headaches					Blurred Vision				
Migraines					Floaters				
Stiff Neck					Burning				
Dizziness					Dry				
Fainting					Tearing				
Swollen Glands					Infammation				
Skin					Itchy				
Dry Skin					Styes				
Bruising Easily					**Ears**				
Rashes					Ringing				
Itching					Hearing Loss				
Changes in Moles					Infections				
Night Sweating					Earaches				

	Often	Seldom	Severe	Mild		Often	Seldom	Severe	Mild
Respiratory					**Cardio-Vascular**				
Chronic Cough					Palpiations				
Coughing Blood/Phlegm					Chest Pain/Tightness				
Difficulty Breathing					Cold Hands/Feet				
Wheezing/Asthma					Swollen Ankles				
Frequent Colds					Low Blood Pressure				
Pneumonia/Bronchitis					High Blood Pressure				
Other					Blood Vessel Problems				
Genito-Urinary					Other				
Pain on Urination					**Neurological**				
Frequent Urination					Seizures				
Blood in Urine					Tremors				
Urgency to Urinate					Numbness				
Unable to Hold Urine					Tingling				
Other					Pain				
Muscles & Joints					Paralysis				
Sore Muscles					Poor Coordination				
Weak Muscles					Other				
Back ache					**Gastro-Intestinal**				
Back Pain					Poor Appetite				
Joint Disorders					Excessive Appetite				
Difficulty Walking					Nausea				
Other					Vomiting/Belching				
Male					Indigestion				
Pain/Itching of Genitalia					Stomach Pain				
Genital Lesions					Abdominal Pain				
Discharges					Diarrhea				
Impotence					Blood in the Stool				
Premature Ejaculation					Black Stool				
Weak Urinary Stream					Hemorroids				
Lumps on Testicles					Other				
Other									

Infectious Screening – Please Check if True

___ Engage in Safe Sex ___HIV Risk – Self or Partner ___ TB Risk – Self or Partner

___ Hepatitis – Self or Partner ___ Blood Transfusions

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Past Medical History (with Dates)

Significant Illnesses:

Major Hospitalizations:

Significant Traumas (Auto Accidents, Falls, etc.):

History of Sexually Transmitted Diseases: Self or Partner

___ Gonorrhea ___Chlamydia ___ Herpes (Oral / Genital)

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Please state any other concerns you would like to discuss and what you expect to gain from treatments.

Patient Signature ____ Date ________________________

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Acupuncture Informed Consent

I, the undersigned, agree to acupuncture treatment and have read and understood the following possible ill-effects that occur in some people at some times, despite all usual care.

Fainting may occur, particularly if the patient is very hungry, very tired, very nervous, or under the influence of alcohol or drugs. You will usually be treated lying down to minimize this possibility. Arriving rested, fed and sober helps prevent this.

Tiny bruising occurs if the acupuncture site is moved by the patient during treatment or if a vessel is nicked during insertion. Rest still and ask your therapist to remove any needles if you need to move yourself for any reason.

All infection is avoided by use of sterile equipment. Sterility of needles is guaranteed by your acupuncturist or by the manufacturer of disposable equipment.

Cupping or gwasha will leave skin discoloration but not bruising that resolves itself in three days to one week. These techniques are used to relieve muscular pain and release trapped metabolic solids; i.e. lactic acid. This discoloration is the expected result of cupping or gwasha, not ill-effect.

Moxibustion is a heat therapy. A stray ash may cause a pin point burn on a fair skinned person. If kept clean this resolves by itself in a few days. Care is exercised to minimize this occurrence.

____
Print Name

____
Signature

____
Date

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OFFICE POLICY/FINANCIAL POLICY

Patients are required to complete all necessary paperwork.

Changes in appointments require advance notice. Please notify the office as soon as possible to reschedule your appointment. This will ensure that you get the treatment results you deserve.

Patients without insurance coverage are expected to pay in form of cash, check, or credit card the same day services are rendered.

For our patients with assignable insurance coverage we have made an effort to remove the financial burden of your health care bills. We are one of the few healthcare providers that will accept assignment of benefits. Our center will render treatment and wait to be reimbursed by your insurance company.

We will assist you in any way we can with your insurance carrier, but any insurance or financial obligations are the full responsibility of the patient.

HMO/PPOs: Please be secure that we are participating in your plan and any precertification and/or referrals are the patient's responsibility.

This office is unique in its ability to offer Medical, Chiropractic, Acupuncture as well as Physical Therapy. Please understand that any treatment prescribed is done on the basis of medical necessity in order to resolve your condition and prevent recurrence.

Please feel free to ask any questions that remain unanswered, we wish to be of assistance in any way we can.

THANK YOU FOR CHOOOSING PARAMUS MEDICAL & SPORTS REHABILITATION CENTER FOR ALL OF YOUR HEALTH CARE NEEDS!!!

____ ________________________
Patient's Name Date

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PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry to the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. Understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or maybe liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

HMO DISCLAIMER: I certify that I am not enrolled in any Health Maintenance Organization (HMO) Subsequent rejection of a claim as a result of this admission, due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFROMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII and/or Title XI of Social Security Act is correct. I authorize any holder of medical or other information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

PREGNANCY: By my signature on this form I do hereby state that to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

Patient's Name ____________________ Date ____________________

Legal Assignment of Benefits and Release of
Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee benefits coverage with ___________________________________ and hereby assign and convey directly to Paramus Medical and Sports Rehabilitation Center LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and of outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage any any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies.

Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____________________________ ____

Signature of Insured/Guardian DATE

Relationship to Guardian to Minor Child ____

PRIVACY PRACTICES ACKNOWLEDEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ____________________________________ Birthdate __________________________

Signature ____

Date _______________________

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