Pisker Family Chiropractic Center
1903 Kings Highway Swedesboro, NJ 08085
(856) 467-9600

Welcome to Our Office!

Name:_____ Preferred Name:_____ Date: _____

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

Home Phone:_____ Cell :_____Primary Physician:_____

Occupation: _____ Employer: _____

Date of Birth:____/____/_____ SS#:_____-_____-_____ Height:_____ Weight:_____ Shoe Size:_____

Marital status: ○Single ○ Married ○Separated ○Divorced ○ Widowed Spouse's Name:_____

Children's Name(s) & Ages:_____

Blood Pressure:_____ Ethnicity:_____ Language:_____

Are you a smoker?○Yes ○ No If yes, do you plan on quitting? ○ Yes○ No. If you already quit, what was your approximate quit year? _____ Email Address:_____

List any prescription medications you are currently taking:_____

_____

List any prescription medications you are allergic to:_____

_____

Favorite Hobbies or Interest:_____

Have you ever had chiropractic care before: ○ Yes○No when and for what purpose?

_____

How did you hear about our office?_____

What are your current chief complaints?_____

When did the problem begin? _____ How did it occur? _____

Have you had the same or similar problems in the past? ○Yes ○ No

How many episodes have you had? ○ N/A ○first time ○1 ○ 2 ○3 ○ Greater than 3

Have you seen another Doctor for this problem: ○Yes ○ No When? _____

Treatment Given? _____ Did it help? ○ Yes ○ No

Regarding your chief complaint (s), what makes it feel better? (ex. Ice, laying down) _____

What makes it feel worse? (ex. Lifting, sitting, bending)_____

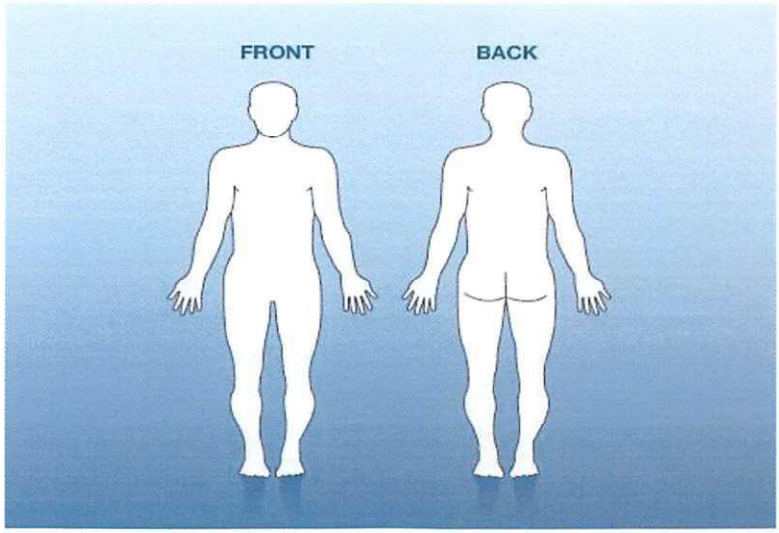
How would you describe the pain / discomfort? (ex. Sharp, stiff, numb, ache)_____

Does the pain/discomfort worsen during a particular time of day?○ Yes ○ No When? _____

Does the pain/discomfort radiate to another area (ex. Lower back to ankle) _____

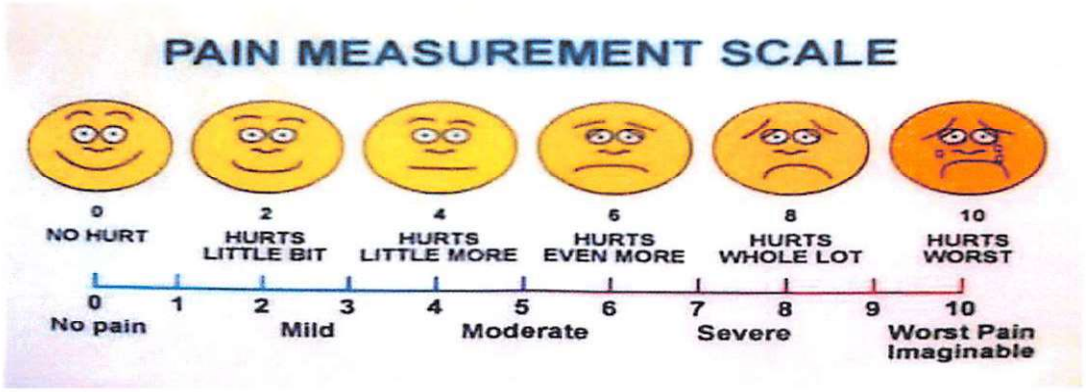
Please mark the diagram regarding your complaints.

A=Aching B=Burning S=Sharp T=Throbbing ⟹ = Radiates C=Stiff O=Other T=Tickling



Is the pain constant? ○Yes ○ No

Please rate the severity of your pain or discomfort



Do your symptoms interfere with: ○ work ○sleep ○ dressing ○ hobbies ○other: _____

Is your condition: ○ getting worse ○ more frequent ○ more intense

○ Lasting longer than past episodes

How would this problem affect your life if it gets worse over time? _____

Is there any reason that would prevent you from getting the treatment that you need to correct this problem? _____

Have you ever suffered from any of the following: **(Check all that apply)**

- ○ Neck pain
- ○ Low back pain
- ○ Headache
- ○ Migraines
- ○ Arm / back tingling
- ○ Shoulder pain
- ○ Hand pain / tingling
- ○ Leg pain / tingling
- ○ Jaw pain
- ○ Chest pain
- ○ Lung problems
- ○ Heart problems
- ○ Abnormal blood pressure
- ○ Irregular heartbeat
- ○ Ankle swelling
- ○ Cold extremities
- ○ Blurred vision
- ○ Vision problems
- ○ Difficulty breathing
- ○ Stuffy nose
- ○ Allergies
- ○ Fainting
- ○ Weight loss
- ○ Poor appetite
- ○ Excessive appetite
- ○ Nervousness
- ○ Confusion
- ○ Depression
- ○ Dental problems
- ○ Excessive thirst
- ○ Frequent nausea
- ○ Vomiting
- ○ Prostate problems
- ○ Breast pain / lump
- ○ Cramps
- ○ Painful urination
- ○ Bladder trouble
- ○ Excessive urination
- ○ Discolored urine
- ○ Gas / bloating after meals
- ○ Heartburn
- ○ Colitis
- ○ Irritable bowel
- ○ Black or bloody stools
- ○ Constipation
- ○ Hemorrhoids
- ○ Liver problems
- ○ Stroke
- ○ Paralysis
- ○ Tingling
- ○ Numbness
- ○ Fatigue
- ○ Dizziness
- ○ Loss of sleep
- ○ Difficulty hearing
- ○ Ear pain

How many hours of sleep do you get on an average night? **(Circle one)** 5 6 7 8 9 10 10+

Do you wake up refreshed? ○ Yes ○ No Do you feel you are under a lot of stress? ○ Yes ○ No

How much water do you drink per day? _____

How many meals do you eat per day? _____

Do you have digestive problems? ○ Yes ○ No

(Circle all that apply): Gas Bloating Heartburn diarrhea constipation

Does your jaw pop, click, or cause Pain when chewing? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No How long? ○ 1-5 years ○ 5-10 years ○ 10+ years

Do you drink alcohol? ○ Daily ○ Weekly ○ Occasionally ○ N/A

How much coffee _____ oz. And soda _____ oz. do you generally drink per day?

Do you exercise? ○ Never ○ Daily ○ 1-2 x / wk ○ 3-5 x / wk ○ Aerobic strengthening ○ Stretching

The pain/discomfort with: (Circle all that apply):

Shoulders L/R Elbows L/R Wrist/hands L/R Hips L/R Knees L/R Ankles / Feet L/R

Are you currently under the care of another Dr.? ○ Yes ○ No For what? _____

List surgeries you had an approximate date: _____

List broken bones or traumas (ex. Auto accident, falls, etc...) and approximate dates:

_____

Have you ever been knocked unconscious? ○ Yes ○ No

Are you or do you think you may be pregnant? ○ Yes ○ No ○ Unsure

Are you seeking care for: ○ Heath Maintenance / Optimization ○ Health Problem ○ Both

Would you be interested in attending a workshop on: (Circle all that apply)

The health benefits of chiropractic **Nutrition** **How to reduce toxins in your body**

Improving positive thinking

Is there anything else you would like us to know regarding your health?

_____

_____

Signature: _____ **Date:** _____

Metabolic Assessment Form™

Name: ______________________ **Age:** _____ **Sex:** _____ **Date:** ______________

PART I

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

1. ______________________ **4.** ______________________
2. ______________________ **5.** ______________________
3. ______________________

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

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 movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; 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 of 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				
Difficulty digesting roughage and fiber	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
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII				
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
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 IX				
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 X				
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 between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI				
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

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

Category XII				
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 XIII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a 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 XIV				
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 XV				
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 XVI				
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 XVI *(Cont.)*				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(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 XVIII *(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 XIX *(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 XX *(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:

_____

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Stephen A. Pisker, D.C.
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856-467-9600 • Fax 856-467-1314

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this office:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctor of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this office, it's nature, or cost in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements,

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature of Patient or Guardian if a minor) (Date)

_____I consent to receive communication from PC via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.
(Initial)

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete descriptions of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____
(Signature of Patient or Guardian if a minor) (Date)

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Dr. Stephen A. Pisker D.C.

1903 Kings Highway
Swedesboro, NJ 08085
856.467.9600 www.drpisker.com

HIPPA NOTICE FOR PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and provide individuals with this Notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any questions, please speak with our HIPPA Compliance Officer in person or by phone at our main number.

Your signature below is an acknowledgment that you have received this Notice of our Privacy Practices.

By signing this form, you are also allowing our office to:

1. Confirm appointments at your home by phone or answering machine;
2. Disclose medical information requested by other treating physicians;
3. Disclose medical information to your lab/insurance company;
4. Request medical records when necessary from physicians or health care facilities.

I hereby give permission to disclose health information (i.e. test results) about me to the following people: (please print name on the line provided)

Spouse: _____
Son/Daughter: _____
Mother/Father: _____
Other: _____

I have the right to withdraw or revise my permission at any time, in writing.

PRINT PATIENT NAME: _____
SIGNATURE: _____ **Date:** _____