**The Holton Center for Integrative Healthcare**

289 Central Ave., Metuchen, NJ 08840

Patient Name_____ Date: _____ Email: _____

SS#/SIN_____ DOB_____ □ Male □ Female Home phone_____ Cell Phone _____

Check appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____ Spouse or Guardian's name_____

Spouse's Employer_____ Emergency Contact Name: _____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

**How did you hear about us?** (Check appropriate box)

□ Facebook □ Dinner Seminar □ Health Fair □ Event at Work □ Former Patient □ Internet Search □ Website

□ Webinar □ Referral (Name) _____ □ Location □ Other (Please Note) _____

**Responsible Party**

Name of The Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Date of Birth: _____ Is the person currently a patient at our office? □ Yes □ No

**Do you have any Medical insurance?** □ Yes □ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **YOUR BUSINESS NAME** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20____.

X_____ (SEAL)
(Patient signature)

X_____ (SEAL)
(Signature of Guardian if applicable)

X_____
(Please print patient name)

## Health History

Patient Name: _____ DOB: _____ Date: _____

**Chief Complaint:** _____

**History of Present illness:**

**Location:** _____
(Where is the pain/problem?)

**Severity:** _____
How severe is the pain/problem on a scale of 1-10 with 10 being the most severe? List your range of pain.
When is it at its worst and best?

**Timing**: _____
(Does the pain/problem occur at a specific time?)

**What other areas of your body are affected by this problem?**

_____
_____
(Example: Ankle problem due to knee problem …)

**Are you on any medications now for this problem?** _____

**What have you tried in the past to help your problem?**

_____
(Heat, Ice, over the counter medications. Prescription medications, rest, exercise, PT, chiropractic, massage)

**Duration:** _____
(How long have you had this pain/ problem? When did it start?)

**What activities have you given up or changed due to this problem?** _____
**(**Example: stopped climbing the steps as often)

**What activities increase symptoms/make problems worse?**
(What makes the pain/problem worse or better? Example: Going up/down stairs, brushing hair, etc.)

**Past Medical History**

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Measles…… | NO | YES | Anemia…… | NO | YES | Back Trouble……. | NO | YES | Hepatitis…… | NO | YES |
| Mumps…… | NO | YES | Bladder Infection…… | NO | YES | High Blood Pressure… | NO | YES | Ulcer…… | NO | YES |
| Chicken Pox…… | NO | YES | Epilepsy…… | NO | YES | Low Blood Pressure……. | NO | YES | Kidney Disease…… | NO | YES |
| Whooping Cough… | NO | YES | Migraine Headaches. | NO | YES | Hemorrhoids…… | NO | YES | Thyroid Disease……. | NO | YES |
| Scarlet Fever…… | NO | YES | Tuberculosis…… | NO | YES | Bleeding Tendency……. | NO | YES | Venereal Disease… | NO | YES |
| Diphtheria…… | NO | YES | Diabetes……. | NO | YES | Mitral Valve Prolapses. | NO | YES | Stroke…… | NO | YES |
| Small pox…… | NO | YES | Cancer……. | NO | YES | Hives of Eczema…… | NO | YES | Asthma…… | NO | YES |
| Pneumonia…… | NO | YES | Polio……. | NO | YES | Venereal Disease… | NO | YES | Bronchitis…… | NO | YES |
| Rheumatic Fever… | NO | YES | Glaucoma…… | NO | YES | Infectious Mono…… | NO | YES | AIDS & HIV…… | NO | YES |
| Arthritis…… | NO | YES | Hernia…… | NO | YES | Venereal Disease… | NO | YES | Bronchitis…… | NO | YES |

Blood or Plasma Transfusion……NO YES Any Other Disease… NO YES **(Please List):** _____
_____

| **Previous Hospitalizations/Surgeries/Serious Illnesses** | When? | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medication:** (include nonprescription)

_____
_____

**Primary Care Physician**: _____

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

**Do you have a sulfa allergy?** NO YES

**Allergies/Medication Allergies:**

_____
_____

**CLINICIAN SIGNATURE:** _____ **DATE REVIEWED:** _____

Name: _____ DOB _____ Date: _____

## Patient Social History:

| | | | | | |
|---|---|---|---|---|---|
| Marital Status | Single: _____ | Married: _____ | Separated: _____ | Divorced: _____ | Widowed: _____ |
| Use of Alcohol | Never: _____ | Rarely: _____ | Moderate: _____ | Daily: _____ | |
| Use of Tobacco | Never: _____ | Rarely: _____ | Moderate: _____ | Daily: _____ | |
| Use of Drugs | Never: _____ | Type/Frequency: _____ | | | |

**Family Medical History:**

| | Age | Disease | If Deceased, Cause Of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse: | _____ | _____ | _____ |
| Children: | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

| **Muscular/Skeletal** | | **Neurological** | | **General** | |
|---|---|---|---|---|---|
| Muscle Aches | 1 2 3 4 5 | Headaches | 1 2 3 4 5 | Fatigue | 1 2 3 4 5 |
| Fibromyalgia | 1 2 3 4 5 | Migraines | 1 2 3 4 5 | Malaise | 1 2 3 4 5 |
| Arthritis | 1 2 3 4 5 | Dizziness | 1 2 3 4 5 | Weakness, tiredness | 1 2 3 4 5 |
| Joint Pain | 1 2 3 4 5 | Numbness | 1 2 3 4 5 | Lightheadedness | 1 2 3 4 5 |
| Low Back Pain | 1 2 3 4 5 | Tingling in hands or feet | 1 2 3 4 5 | Irritability | 1 2 3 4 5 |
| Neck Pain | 1 2 3 4 5 | Pins/needles in hands or feet | 1 2 3 4 5 | Constipation | 1 2 3 4 5 |
| Wrist/Hand Pain | 1 2 3 4 5 | Burning in hands or feet | 1 2 3 4 5 | Diarrhea | 1 2 3 4 5 |
| Elbow Pain | 1 2 3 4 5 | Hypersensitivity | 1 2 3 4 5 | Feeling foggy | 1 2 3 4 5 |
| Shoulder Pain | 1 2 3 4 5 | Difficulty with balance | 1 2 3 4 5 | Forgetfulness | 1 2 3 4 5 |
| Hip Pain | 1 2 3 4 5 | | | | |
| Knee Pain | 1 2 3 4 5 | | | | |
| Ankle/Foot Pain | 1 2 3 4 5 | | | | |
| Pain b/t shoulder blades | 1 2 3 4 5 | | | | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

_____ _____
Signature of Person hooking POA for patient Date

_____ _____
Doctor's Review Signature of Doctor Date

**PATIENT CONSENT TO TREAT:**

I hereby authorize the Doctor's/Nurse Practitioner of The Holton Center for Integrative Healthcare to treat my case as they deem appropriate through the use of lab testing, trigger point injections, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, and diagnostic testing. I realize the goal of holistic health care is to strengthen the patient's body in order to heal themselves.

The patient agrees that he/she is responsible for all bills incurred at this office.

Signature: _____ Date: _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

I acknowledge that I have received The Holton Center's Notice of Privacy Practices for protected health information.

DATE: _____ Name of Patient: _____ (DOB) _____

Signature of Patient/Personal Representative: _____