Joel M. Berger, MS, DC, DABCN
Diplomate American Board of Chiropractic Neurology

Confidential Client Information

Name: _____ Sex: M F Age: _____ DOB: _____ Date: _____

Address: _____ City_____ State _____ Zip _____

Home Phone: (_____) _____ Business Phone: (_____) _____ Mobile Phone: (_____) _____

Fax: (_____) _____ Email: _____ I prefer contact via: ❑ Phone ❑ Email ❑ Mail

Occupation: _____ Employer: _____

Names/Ages of Children: _____ Marital Status: MARRIED SINGLE WIDOWED DIVORCED

Name of Spouse: _____ Spouse"s Employer:_____

Name and Phone of Emergency Contact: _____ Relationship: _____

Have you ever received chiropractic care? ❑ Y ❑ N If yes, which doctor? _____ Phone: _____

Do you have a primary care physician? ❑ Y ❑ N If yes, which doctor? _____ Phone: _____

Payment Information | Please indicate your preferred form of payment

❑ Cash ❑ Check ❑ Visa, Mastercard ❑ Health Savings Account (HSA)

How did you hear about our office?

❑ Internet Search Engine: ❑ Google ❑ Yahoo ❑ Yelp ❑ Facebook ❑ Linkdin ❑ Workshop/Seminar (please specify) _____

❑ Personal Referral by: _____ Other: _____

Current Health Concerns | Please list your 5 major health concerns in the order of importance, (i.e. headaches, neck pain, etc)

Issue & Brief History. Please include when you first noticed the problem:	Is this condition...	
1.	being treated?	❑ Y ❑ N
	due to accident?	❑ Y ❑ N
	getting progressively worse?	❑ Y ❑ N
2.	being treated?	❑ Y ❑ N
	due to accident?	❑ Y ❑ N
	getting progressively worse?	❑ Y ❑ N
3.	being treated?	❑ Y ❑ N
	due to accident?	❑ Y ❑ N
	getting progressively worse?	❑ Y ❑ N
4.	being treated?	❑ Y ❑ N
	due to accident?	❑ Y ❑ N
	getting progressively worse?	❑ Y ❑ N
5.	being treated?	❑ Y ❑ N
	due to accident?	❑ Y ❑ N
	getting progressively worse?	❑ Y ❑ N

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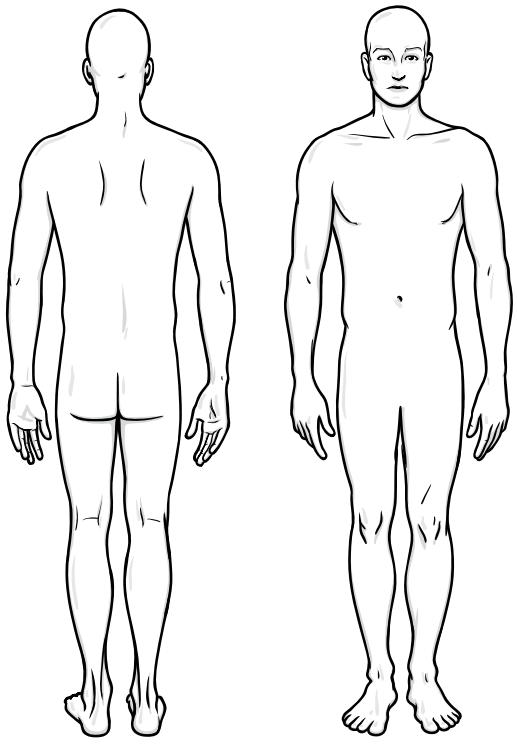
Health History | Pain Presentation

Using the diagram below, mark areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the right by circling the number that best represents your pain, where 1 is no pain and 10 is the worst pain you can imagine.



Rate your pain by circling the one number that best describes your pain…

…at its WORST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

…at its LEAST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

…on AVERAGE for the past WEEK.

1 2 3 4 5 6 7 8 9 10

Scars: Use the diagram to the left to draw any scars (major or minor) thay you have.

Health History | Head, Neck, Back, Extremeties

Check those appropriate to you:

Head
- ❑ Headache
- ❑ Migraine
- ❑ "Sinus" Headaches
- ❑ Dizziness
- ❑ Light Headache
- ❑ Hearing Loss
- ❑ Ringing in Ears

Neck
- ❑ Pain
- ❑ Stiffness
- ❑ Weakness
- ❑ Grinding
- ❑ "Pinched" Nerve
- ❑ Feels Out of Place

Shoulders
- ❑ Pain Across Shoulders
- ❑ Pain in Shoulder Joint
- ❑ Pain with Movement
- ❑ Difficulty Raising Arm
- ❑ "Pinched" Nerve
- ❑ Grinding/Popping

Mid & Upper Back
- ❑ Pain
- ❑ Stiffness
- ❑ Tension
- ❑ Muscle Spasm
- ❑ "Pinched" Nerve

Low Back
- ❑ Pain
- ❑ Stiffness
- ❑ Weakness
- ❑ "Pinched" Nerve
- ❑ Feels Out of Place

PAIN WORSE WITH:
- ❑ Sitting ❑ Stooping
- ❑ Standing ❑ Lifting
- ❑ Bending ❑ Coughing
- ❑ Twisting

Arms & Hands
- ❑ Pain ❑ LEFT ❑ RIGHT
- ❑ Weakness ❑ LEFT ❑ RIGHT
- ❑ Numbness/ Tingling ❑ LEFT ❑ RIGHT
- ❑ "Pins & Needles" ❑ LEFT ❑ RIGHT
- ❑ Cold Hands ❑ LEFT ❑ RIGHT

Hips, Legs, & Feet
- ❑ Pain in Buttock/Hip ❑ LEFT ❑ GHT
- ❑ Pain in Knee ❑ LEFT ❑ RIGHT
- ❑ Pain in Ankle ❑ LEFT ❑ RIGHT
- ❑ Numbness/Tingling-Thigh ❑ LEFT ❑ RIGHT
- ❑ Numbness/Tingling-Leg ❑ LEFT ❑ RIGHT
- ❑ Weakness ❑ LEFT ❑ RIGHT
- ❑ "Pins & Needles" ❑ LEFT ❑ RIGHT
- ❑ Cold Feet ❑ LEFT ❑ RIGHT

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Review of Symptoms | Current and Past History

Please check the boxes for all conditions that you are currently experiencing and/or have experienced in the past:

General
❑ Weight loss
❑ Weight gain

Head
❑ Headache
❑ Dizziness
❑ Head trauma
❑ Fainting
❑ Blacking out

Eyes
❑ Change in vision
❑ Cataracts
❑ Light sensitivity
❑ Flashes in vision
❑ Spots in vision

Mouth
❑ Bleeding gums
❑ Cold sores
❑ Dentures
❑ Sore throat
❑ Jaw pain
❑ Changes in taste
❑ Hoarseness

Nose
❑ Nosebleeds
❑ Sinus problems

Lungs
❑ Difficulty breathing
❑ Asthma
❑ Pneumonia
❑ Wheezing
❑ Persistent cough
❑ Coughing blood
❑ Tuberculosis

Vascular
❑ Chest pain
❑ Palpitations
❑ Ankle swelling
❑ Cold feet/hands
❑ Leg cramps
❑ Calf pain
❑ Varicose veins
❑ Low blood pressure
❑ High blood pressure

G-I System
❑ Gas
❑ Heartburn
❑ Indigestion
❑ Ulcers
❑ Vomiting/Nausea
❑ Abdominal Pain
❑ Diarrhea
❑ Constipation
❑ Blood in stool
❑ Hemorrhoids
❑ Gall bladder disease
❑ Liver disease

G-U System
❑ Difficulty urinating
❑ Pain urinating
❑ Blood in urine
❑ Incontinence
❑ Foul odor of urine
❑ Increased urination
❑ Decreased urination
❑ Urinary infection
❑ Genital infection

Neurologic
❑ Seizures/Epilepsy
❑ Strokes
❑ Tingling sensation
❑ Numbness
❑ Weakness
❑ Difficulty walking
❑ Poor coordination

Muscle/Bone
❑ Joint pain
❑ Stiffness
❑ Muscle ache
❑ Arthritis
❑ Bone pain
❑ Fractures
❑ Dislocations

Skin
❑ Rash
❑ Bruising
❑ Brittle nails
❑ Changes in moles
❑ Itching
❑ Peeling

Conditions
❑ Hypertension
❑ Diabetes
❑ Thyroid condition
❑ Heart condition
❑ Rheumatic arthritis
❑ Rheumatic fever
❑ Glaucoma
❑ Alcoholism
❑ Cancer/Tumor
❑ Polio
❑ Parkinson's
❑ Multiple Sclerosis
❑ Gout
❑ Anemia
❑ Osteoporosis
❑ Osteoarthritis
❑ High cholesterol
❑ Migraines
❑ TIAs
❑ Headache unlike any previously experienced

Do you currently take prescription medication? ❑ Yes ❑ No If yes, please describe: _____

_____

Do you take over-the-counter medication? ❑ Yes ❑ No If yes, please describe: _____

_____

Do you currently take any vitamins, supplements, herbs, and/or homeopathy? ❑ Yes ❑ No If yes, please describe: _____

_____

Any previous surgical procedure(s)? ❑ Yes ❑ No If yes, please explain: _____

_____

Review of Symptoms | Women Only

Are you pregnant? ❑ Yes ❑ No

Type of Birth Control: _____

Date of Last Period: _____

❑ Bleeding Between Periods ❑ Heavy or Prolonged Bleeding ❑ Severe Menstrual Pain

Date of Last OB/GYN exam: _____

❑ Abnormal Pap Smear ❑ Breast Lump(s) ❑ Cancer ❑ Other: _____

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Office Guidelines and Policies

Welcome! Please take the time to review the following office guidelines and policies so that we may better serve you. The information outlines our terms for providing service and will help clarify any questions you may have before making an appointment.

Medical Records
If applicable, please bring copies of your latest laboratory and imaging (x-ray, MRI, CT) reports on the day of your initial exam. If your doctor requires an "Authorization to Release Medical Records" form, please contact our office and we will provide one for you. Often your laboratory and imaging reports can be faxed to you by your physician's office or are accessible online. You may fax your results to Dr. Berger at 408.973.9586 (please phone ahead) or email at jbergerfnxmed@gmail.com.

Initials _____

Payment Terms
Payment for services is due on the day they are rendered unless a prior agreement has been made. We accept cash, check, credit cards, or Health Savings Account cards (HSA). This office does not handle insurance billing, however a super bill can be provided upon request that may be submitted by you to your insurance carrier for reimbursement. Please note however, insurance companies do not always compensate for the full amount of your bill, even when the treatment is authorized and the insurance company has claimed that the treatment would be covered in full. Costs for nutritional or other products are due once in the patient's possession. In the case that you suspend or terminate your care, any outstanding balances for rendered services or product received are due and payable by you immediately.

Initials _____

No Show & Cancellation Policy
Our office is committed to offering the best service to our patients and we commit the best resources available to your appointment. Therefore, we require a minimum of 24-hour cancellation notice on all appointments. No-shows or cancellations with less than a 24-hour notice will be billed the full fee of the appointment.

Initials _____

Retail Sales
Dr. Berger will often recommend nutritional support products such as vitamins, minerals, enzymes, herbs, homeopathy, etc. He carefully selects "professional" grade products not sold directly to the public, from various reputable manufacturers. The costs of these products, if needed, are not included in the evaluation or consultation fees. No patient is required to purchase products from our office.

Initials _____

Product Returns
Product returns must be made within thirty (30) days of purchase. Unopened products such as supplements that are returned within 30 days will be given a full refund, less a 10% restocking fee. All supplement returns must be unopened, sealed, and inside the original packaging. Opened supplements may not be returned. No refunds are offered on services rendered.

Initials _____

The Nature of Chiropractic
"Chiro" means "hands", so chiropractic is the art of the healing with the hands. This means that the doctor may palpate and adjust all areas of the spine, from the neck to the sacrum as well as other joints of the body (every joint in the body can be adjusted). Also, some of our therapeutic modalities, such as massage, myofascial release and interferential involve placing of the hands or equipment on the body. Because everyone has his/her own comfort level with his/her body and with being touched, please keep an open communication with us regarding your own comfort level. Also, there are many ways to adjust the joints and to apply therapeutic modalities. With your feedback, we can find the technique and modalities that work best for you and with which you are most comfortable.

Initials _____

Communication
We are here to serve you. Please speak with us about any concerns that may arise at any time. By communicating how your are experiencing care in our office, you enable us to provide you with the best possible service.

Initials _____

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Informed Consent

Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care with Dr. Berger, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I, the undersigned, certify that the information provided by me is correct to the best of my knowledge and am solely responsible for any incorrect information I may have given or omissions I may have made. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Name (Printed)	Signature	Date

I authorize treatment for my minor child as deemed necessary by my doctor.

Responsible Party's Name (Printed)	Responsible Party's Signature	Date

Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, section 201(g)(1), the term 'drug' is defined as an 'article intended for use in diagnosis, cure, mitigation, treatment, or prevention of disease'. Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. Dr. Berger provides nutritional counseling and makes individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biochemical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep Dr. Berger and any other healthcare providers involved in your care fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

I have read and understand the above:

Name (Printed)	Signature	Date

If the patient is a minor, or if the patient is being represented by another party:

Personal Representative Name (Printed)	Personal Representative Signature	Date

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HIPPA Guidelines

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care with Dr. Berger, your personal and health related information may be disclosed in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if the employer is responsible for the payment of your services).

- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not home to receive an appointment reminder, a message may be left on your answering machine or voice mail. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive health care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of your privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

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HIPPA Guidelines (continued)

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to Dr. Joel Berger DC. If you would like further information about our privacy policies and practices, please contact Dr. Joel Berger DC.

This notice is effective as of 09/01/2010. This notice and any alterations or amendments made hereto will expire seven years after the date upon the record was created.

My signature acknowledges that I have read and understand the contents of this notice.

Name (Printed)	Signature	Date

If the patient is a minor, or if the patient is being represented by another party:

Personal Representative Name (Printed)	Personal Representative Signature	Date

Description of the authority to act on behalf of the patient