



JERSEY CHIROPRACTIC & WELLNESS CENTER

35 West Main Street, Suite 202
Denville, New Jersey 07834
(973) 625-7800

Dr. Jersey Wulster

Established 1983

Welcome!

The purpose of our office is to support the achievement of your individual health goals. We are committed to educating you about chiropractic care, and other preventative health alternatives. This will help you make informed decisions about your own health choices. We encourage you to educate others, and support your family, friends and coworkers in obtaining and maintaining good health, naturally.

PROCEDURE FOR NEW PATIENTS

- Step 1** All new patients need to fill out a personal health history questionnaire. We require a complete and accurate health history to better serve you.
- Step 2** Your first consultation with the doctor is to thoroughly discuss your health problems, and to undergo a full Chiropractic examination utilizing neurological, orthopedic spinal testing and x-rays if necessary.
- Step 3** On your follow up visit you will be given a complete report of findings by the doctor, who will then advise you of your personalized treatment program necessary for your particular problem.
- Step 4** Our staff will advise you of our office policies, scheduling, and billing procedures. We will be happy to answer any insurance coverage questions, or arrange any financial plans you may need.

*We are here to help you!
Please do not hesitate to ask our staff
if we can be of any assistance to you or your family.*

PERSONAL HISTORY

Name _____ Address _____
 City _____ State _____ Zip _____
 Home Phone: () _____ Cell Phone: () _____ Beeper: () _____
 Email Address: _____
 Social Security #: _____ Birthdate: _____ Age: _____ Sex: _____ M _____ F _____
 Circle One: Single Married Separated Divorced Widowed No. of children: _____
 Your Employer: _____ Type of Work: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Business Phone: () _____ Ext: _____
 Spouse's Employer: _____ Type of Work: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Business Phone: () _____ Ext: _____
 Emergency Contact: _____ Phone: () _____ Relationship: _____
 Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Who is responsible for your Bill: Self _____ Spouse _____ Parent _____ Guardian _____
 What type of insurance do you have: Major Medical Health Ins. _____ Medicare _____ Medicaid _____ None _____
 Insurance Company Name: _____ I.D. No. _____
 Address _____ Group No. _____
 Policy Holder's Name: _____ Policy Holder D.O.B. _____
 Your relationship to the policy holder: _____ Your Driver's License No. _____

PAST HEALTH HISTORY

Below are a list of diseases or conditions which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES THAT YOU PRESENTLY HAVE OR HAVE HAD IN THE PAST:

- | | | |
|---|--|--|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Immune Disorder |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Anemia | <input type="checkbox"/> AIDS/ARC |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | |

INTAKE	How Much Per Day
<input type="checkbox"/> Coffee	_____
<input type="checkbox"/> Tea	_____
<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Cigarettes	_____
<input type="checkbox"/> White Sugar	_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 3 YEARS AND IS STILL A PROBLEM:

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/ Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness
- Shoulder, Knee Pain
- Arthritis

NERVOUS SYSTEM

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Cold/Tingling Extremities
- Stress

GENITO-URINARY

- Bed-wetting
- Blood in Urine
- Frequent Urination
- Bladder Control Problems
- Painful Urination
- Prostate Trouble
- Pus in Urine
- Bladder Infections

CARDIOVASCULAR

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

ENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Recurring Stuffed Nose

FEMALES ONLY:

- Congested Breasts
 - Cramps or Backache
 - Excessive Menstrual Flow
 - Hot Flashes
 - Irregular Cycle
 - Lumps in Breast
 - Menopause
 - Painful Menstruation
 - Vaginal Discharge
- Last menstrual period _____
 Are you pregnant? Yes No
 If yes, how long _____ mo's.
 Number of children _____
 Last Gynecological Exam _____
 OB/GYN Name _____

Have you had any of the following? Please check by indicating your age or the year it was performed:

Major Surgery/Problems _____ Appendectomy _____ Hysterectomy _____ Broken Bones _____ Cancer _____ Hernia
_____ Gall Bladder _____ Back Surgery _____ Tonsilectomy Other _____

Accidents or Major Falls (include all auto accidents): _____

Hospitalization (other than above): For what reason? _____

Previous Chiropractic Care: _____ Yes _____ No Doctor's Name & Approximate Date of Last Visit: _____

Family M.D. _____ Date of Last Exam: _____

Are you under the care of a Physician? _____ Yes _____ No If Yes, For What: _____

Medications you are taking now: None _____ Tranquilizers _____ Pain Killers _____ Thyroid _____ Heart _____
Blood Pressure _____ Birth Control Pills _____ Muscle Relaxants _____ Depression _____
Antibiotics _____ Anti-inflammatory _____ Other _____

Do You Wear: _____ Heel Lifts _____ Sole Lifts _____ Inner Soles _____ Arch Supports _____ Orthotics

Do You:	Y	N	When did you last have:	Never	0-6 mo	6-18 mo	Longer
Take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>	Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

Please check of any of your immediate family suffer from:

_____ Lower Back Pain _____ Neck Pain _____ Headaches _____ Migraines _____ Shoulder Pain
_____ Bursitis _____ Sciatica _____ Heart Problems _____ Cancer _____ Diabetes

CURRENT HEALTH CONDITION

What is your current complaint?: _____

Describe your current Pain: sharp / spasm / sore / burning / throbbing / ache / tingling / weakness / dull / numb / stiff / shooting

Is Condition: Job Related Auto Related Home Injury Fall Gradual Onset Sudden Onset

Date of this onset _____ Is this the first time you injured this? Yes No Is it getting worse? Yes No

Rate the intensity of your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

How often is the pain present?: constant / frequent / occasional / intermittent

Does it bother your: Work Sleep Other (specify) _____

Describe how the problem started: _____

What treatment have you had to date for this condition? _____

Physician and/or Hospital Name _____

What makes it better? _____

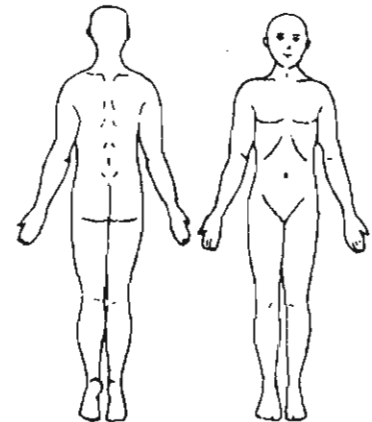
What makes it worse? _____

Current stress level? no stress / minimal stress / moderate stress / greatly stressed

Are there any other areas of pain or discomfort? _____ Yes _____ No

If Yes, where and describe? _____

List Other Complaints _____



Please outline on the diagram the area of your discomfort, and describe your pain: sharp, dull, etc.

AUTHORIZATION TO TREAT & EXAMINE

I hereby authorize Dr. Wulster and the Doctors at Morris County Community Chiropractic Center to examine, x-ray, and treat me (or my child) as he/she determines appropriate through the use of Chiropractic manipulation of the spine, contiguous structures and adjunctive therapy. Any x-rays taken will remain the property of this office, being on file where they may be seen at any time by the patient or released to the patient for 30 days upon signing them out of our office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patients Name (print)

Patient's Signature / parent or guardian

Date

RECORDS RELEASE

To: Morris County Community Chiropractor Center
35 W. Main Street, Suite 202
Denville, NJ 07934
973/625-7800

I hereby authorize Dr. Wulster and the doctors at Morris County Community Chiropractic Center to obtain my x-rays, medical records or any other medical information pertinent to any diagnosis and treatment relating to myself.

Patients Name (print)

Patient's Signature / parent or guardian

Date

ASSIGNMENT OF BENEFITS TO OUR OFFICE

I, hereby request (insurance company name) _____ to make **DIRECT PAYMENT** to Dr. Wulster and/or Morris County Community Chiropractic Center, 35 West Main Street, Suite 202, Denville, New Jersey 07834.

I authorize the reimbursement from my insurance company to Dr. Wulster and/or Morris County Community Chiropractor Center based on any benefits due me under a contract that I have with my medical insurance, personal injury insurance (PIP) and/or workman's compensation insurance.

I am herein noticed that an insurance company, based on its own policies and guidelines, may make determinations of medical necessity different from the doctors at Morris County Community Chiropractic Center. I acknowledge that I have been noticed that the insurance company may not fully reimburse for my chiropractic care even though Dr. Wulster and Morris County Community Chiropractic Center may or may not be a provider. **I agree to be personally responsible for payment of any services rendered to me (or my child) by Dr. Wulster and Morris County Community Chiropractic Center that are not reimbursed by my insurance company.**

I authorize Dr. Wulster to release any information pertinent to my care at Morris County Community Chiropractor Center to any insurance company, utilization review company or attorney that may request records.

Patients Name (print)

Patient's Signature / parent or guardian

Date
