Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ○ M ○ F

Cell Phone: _____ E-mail Address: _____

Social Security # _____ Driver's License Number: _____

Check One: ○ Married ○ Single ○ Widowed ○ Divorced ○ Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____ ☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ○ Yes ○ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ○ Yes ○ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ○ Yes ○ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ○ Yes ○ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases 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 care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ◯ Yes ◯ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

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

GENERAL CODE

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

GASTRO-INTESTINAL CODE

- ☐ 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

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

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

EENT CODE

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

MALE/FEMALE CODE

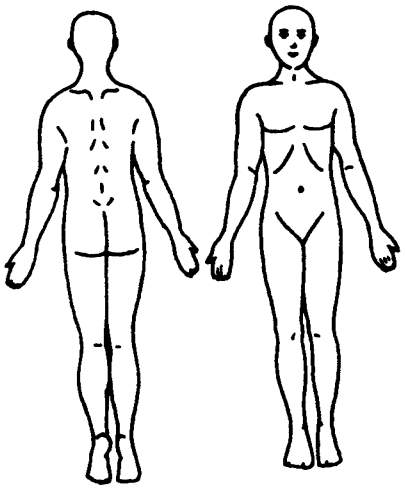
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

◯ Yes ◯ No ◯ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ◯ Yes ◯ No ◯ Referred

_____

Doctor's Signature

PATIENT HISTORY FORM

Pharmasan Labs™

(Provider: **Steven Zodkoy, DC**)

Completion of ALL page(s) required!

Please complete this form; circle or write your answers using a BLACK pen.

Your top 3 health concerns:

1.

2.

3.

Medication / Supplements you are taking:
(exclude NeuroScience products)

Are you or a housemate taking hormones:

	Oral	Patch	Cream	Me	Housemate
Estradiol (E2)					
Estriol (E3)					
Progesterone					
Testosterone					
DHEA					
Melatonin					

NeuroScience products you are taking:
(capsules or sprays)

Product name	*morning*	*afternoon*	*evening*	*bedtime*	**Does it make you feel better?**

General
In the past two weeks have you experienced:

	Not at all	Somewhat	Very often
Anxiety	○	○	○
Feeling panicked or frightened	○	○	○
Irritability	○	○	○
Feeling hyper or revved up	○	○	○
Feeling fidgety or restless	○	○	○
Sadness	○	○	○
Feeling worthless or hopeless	○	○	○
Loss of interest in things you enjoyed	○	○	○
Lack of energy or endurance	○	○	○
Feeling unrefreshed or tired	○	○	○
Low sexual desire	○	○	○
Sexual issues	○	○	○
Hot flashes	○	○	○
Night sweats	○	○	○
Headaches or migraines	○	○	○
Pain or stiffness	○	○	○
Achy joints	○	○	○
Diarrhea	○	○	○
Gas or bloating	○	○	○
Intestinal pain or cramping	○	○	○
Constipation	○	○	○
Heartburn or acid reflux	○	○	○
Inability to lose weight	○	○	○
Weight gain	○	○	○
Food cravings	○	○	○
Difficulty falling asleep	○	○	○
Difficulty staying asleep	○	○	○
Restless sleep	○	○	○
Dizziness	○	○	○
Brain fog	○	○	○
Lack of focus	○	○	○
Forgetfulness or poor memory	○	○	○
Disruptions to your routine by others	○	○	○
Restless legs syndrome	○	○	○

Test-Specific
In the past two weeks have you experienced:

	Not at all	Somewhat	Very often
Stress or worry	○	○	○
Feeling frightened or nervous	○	○	○
Feeling wound up	○	○	○
Making mistakes	○	○	○
Racing thoughts	○	○	○
Anger	○	○	○
Guilt	○	○	○
Feeling isolated and alone	○	○	○
Feeling hopeless	○	○	○
Mood swings	○	○	○
Cold spells	○	○	○
Generalized pain	○	○	○
Sore or painful muscles	○	○	○
Skin rash	○	○	○
Confusion	○	○	○
Inability to recall recent events	○	○	○
Unable to focus on what is being said	○	○	○
Sloppiness or carelessness	○	○	○
Binge eating	○	○	○
Impulsive behavior	○	○	○
Repetitive behavior	○	○	○
Needing to check things over and over	○	○	○
Eating because you feel stressed	○	○	○
Feeling overwhelmed	○	○	○
Inability to stay on top of things	○	○	○
Other people's expectations	○	○	○
Having too much responsibility	○	○	○
Your health issues being physical	○	○	○
Your health issues being stress-related	○	○	○

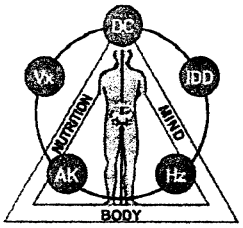
Do the following apply to you:
(Past or Present)

	Yes	No
Hair loss	○	○
Exercise once a week or less	○	○
Exercise five times a week or more	○	○
Dieting failures	○	○
Slow metabolism	○	○

Medical History
Have you ever been diagnosed with:

	Yes	No
ADD / ADHD	○	○
Allergies (Pet, Seasonal, Food, etc.)	○	○
Alzheimer's Disease	○	○
Anxiety / Obsessive Compulsive	○	○
Arthritis	○	○
Asthma	○	○
Autism / Asperger's Syndrome	○	○
Bacterial/Viral/Fungal Infection	○	○
Cardiovascular issues	○	○
Celiac Disease	○	○
Depression	○	○
Fibromyalgia	○	○
High Blood Pressure	○	○
IBS / IBD / Crohn's Disease	○	○
Insomnia	○	○
Lyme Disease	○	○
Metabolic Syndrome	○	○
Migraines	○	○
Parkinson's Disease	○	○
Prostate Cancer	○	○
Restless legs syndrome	○	○
Thyroid Disorder	○	○
Type II Diabetes	○	○

Other:



Monmouth Advanced Medicine LLC

503 Stillwells Corner Road, Freehold NJ 07728
Telephone # 732-308-0099 Fax # 732-308-0347
Advanced Therapies ... Personalized Care

Patient Agreement and Treatment Consent Form

We welcome the opportunity to work with you to help you achieve good health. Our goal is to improve your overall health, decrease your pain and improve your ability to perform the activities of daily living. We will respect you by allowing for the appropriate time to treat you, please do the same by being on time and not missing your appointments.

All insurance policies are different and unique. It is impossible for us to know every detail about every plan, it is your responsibility to understand and check on your insurance, HAS, or FSA health coverage.

Medicare Patients

Dr. Zodkoy does not accept, bill or submit to Medicare. Dr. Zodkoy is not registered with Medicare. If you have Medicare and are treated by Dr. Zodkoy it is an elective service and absolutely no billing to Medicare will occur. You are responsible for 100% of your bill and you will not be reimbursed by Medicare.

Nutritional counseling

Nutritional counseling by Dr. Zodkoy is not covered by insurance, even if Dr. Zodkoy is listed on your plan as a chiropractor. We do not accept, bill or submit to insurance companies for nutritional counseling. All nutritional products in our office are sold at retail, for a profit. You may purchase the same products from an outside source. You are not under any obligation to purchase nutritional products from our office; we provide nutritional products for sale in our office as a convenience to patients. For health and safety concerns we do not accept returns on nutritional supplements. Dr. Zodkoy will not comment on nutritional products he has not recommended, it is impossible for him to know the quality, dosage and characteristics of every product.

Our office does not give advice on medications. If you have a concern or would like to change your medication you need to talk to the prescribing physician.

Risk Factors

It is not uncommon to have increased soreness and discomfort with your care. Chiropractic and physical therapy are active treatments; you need to participate to get the benefits of the care. Muscles, ligaments, tendons and joints may feel more inflamed as they become stronger and more flexible, this is normal and to be expected.

Chiropractic, physical therapy and nutritional care all have an extremely low risk of complications or risk, but they do exist. Patients with cancer, severe osteoporosis, smokers, obesity, on medications, or on OTC are at the greatest risk for side effects. The most common side effects are increased pain and soreness. In extremely rare cases vascular problems may occur. The consult, physical exam, and lab test we perform should minimize any risks.

Fees

The law states that we must itemize every procedure we perform on every visit. Those procedures include; hot packs, ice packs, electrical stimulation, Alpha-Stim, exams, therapeutic exercises, ultrasound, kinetic exercise, kinesiotaping, joint manipulation, soft tissue manipulation, spinal manipulation, laser therapy, IDD Therapy, etc. Each procedure is charged a separate fee from $25-$200 each time it is performed. You will commonly see 4-6 procedures listed on each visit.

Insurance does not cover nutritional counseling, nutritional supplements, laser therapy, NET, IDD Therapy. These are elective services and must be paid for by you.

There is a $50 fee for missed appointments not canceled with 24 hours notice.

Outstanding balances will be assessed interest at a rate of 18 APR. You are responsible for all costs associated with collection proceeding for your account.

Please print any concerns or questions below so that they may be discussed prior to starting your care.

_____

_____

I have read the above, I understand the above and all of my concerns have been listed and answered to my satisfaction. I wish to proceed with care at Monmouth Advanced Medicine.

_____

Print Name Signature Date