



Welcome

Dr. James R. Fedich and staff of Village Family Chiropractic, LLC, welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another healthcare provider, if appropriate.

**Patient Identification:**

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Nickname \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Occupation \_\_\_\_\_  
Age \_\_\_\_\_ Male  Female

**Contact in case of Emergency:**

Name \_\_\_\_\_  
Name of Parent of Minor Patient \_\_\_\_\_  
Email address \_\_\_\_\_

Phone \_\_\_\_\_

**Primary Insurance**

Carrier \_\_\_\_\_  
Active  Y  N

**Secondary Insurance**

Carrier \_\_\_\_\_  
Active  Y  N

**Please check any of the following that you currently or have had in the past 6 months**

- Lose Consciousness
- Double Vision
- Slurred Speech
- Indigestion
- Difficulty Walking
- Nausea, Vomiting
- Numbness on face
- Visual Disturbances
- Arranging Words
- Head Pain unlike any other
- Pain in the Neck, jaw, face
- Ringing in the Ears
- Birth Control Pills
- Cancer
- Pain at Night
- Losing Weight without trying
- Coughing Blood
- Loss of Bowel/ Bladder Control
- Headaches for Hours
- Stroke
- Chest Pain
- Change in Bowel, Bladder habits
- Sore that does not heal
- Unusual Bleeding
- Change in your breasts
- Change in your warts
- Nagging Cough
- Night Sweats
- Drooping Eyelids
- Change in Pupils
- Prescription Medications:
  - High Blood Pressure
  - Blood Thinners
  - Herbs/ Vitamins
  - Other \_\_\_\_\_

Are you seeing any other doctor now for any reason?  Yes  No  
If Yes, Who? \_\_\_\_\_ and For What? \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Any Previous surgeries  Yes  No,  
If yes, type and Date of surgery? \_\_\_\_\_

Are you taking herbs, nutraceuticals, botanicals, or vitamins?  
Please list \_\_\_\_\_

What was the date of onset of your last menses? \_\_\_\_\_

Are your injuries related to any accident?  Work  Auto  Other

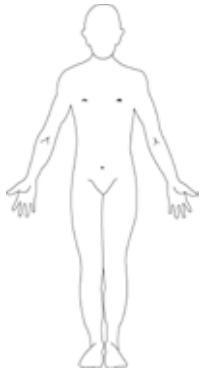
**Social History**

SMOKER  Yes  No If Yes, how many packs \_\_\_\_\_  
ALCOHOL  Yes  No If Yes, how much \_\_\_\_\_

## Family History

Did you mother or father have any of the following.  
Please check: **M** for Mother, **F** for Father, and **B** for Both.

M	F	B		M	F	B	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ulcer or Stomach Problems
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke - <i>Please indicate age when stroke occurred:</i>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema				Mother _____ Father _____
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Seizure-Convulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arthritis-Rheumatism
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HIV Positive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Illness
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid Disease
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Circulation Problems



Mark your area of Pain

Which services here are you interested in?

- Chiropractic
- DRX spinal decompression
- Nutrition Counseling
- Weight Loss
- Cold Laser Therapy
- Other

Rate Your Pain from the Least 0  10 Most

Your Present Complaint \_\_\_\_\_

Briefly Describe your Symptoms \_\_\_\_\_

How Long has this been bothering you? \_\_\_\_\_

What other treatments have you tried? \_\_\_\_\_

How many Doctors have you seen for this? \_\_\_\_\_

Has it helped?  Yes  No

Does your condition interfere with your sleep?  Yes  No

Any Activities you can no longer perform?  Yes  No

If yes, please describe: \_\_\_\_\_

Are you frustrated with your condition?  Yes  No

How has your condition negatively affected you?  Work  Family  Activities

Have you been able to work as well as you could before?  Yes  No

What time of day does it bother you the most?  Early AM  Mid day  After work  Night

Are you taking any medications to deal with this?  Yes  No

If yes, please list: \_\_\_\_\_

I authorize and direct that payment be made directly to Village Family Chiropractic, LLC, and Dr. James R. Fedich, chiropractor of Panther Valley Village Square, Route 517, Allamuchy, NJ 07820. For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I understand and agree that Dr. James R. Fedich of Village Family Chiropractic, LLC, has the right to refuse to accept me as a patient any time before treatment begins. The taking of a history and the conducting of a physical exam are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether or not to accept me as a patient. I authorize Dr. Fedich to send my health care information to other doctors, including my primary care doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature \_\_\_\_\_ Date \_\_\_\_\_