ADVANCED PERFORMANCE AND REHABILITATION CENTER

532 Old Short Hills Road
Short Hills, New Jersey 07078
973-467-9011

Name: ______________________________ Age: _________ Today's Date: ___________
Address: ____
Residence and Mailing City State Zip Code
Home Phone ( )__________ Work Phone ( )__________ Cell Phone ( )___________
Social Security # ____________________ Male ___ Female ___ Birth Date __________
Occupation/Employer's Name & Address ____________________________________
Single __ Married __ Divorced __ Widowed ___ E-mail Address_________________
Insured Name__________________ Employer_______________ Birth Date__________
Who may we thank for referring you to our office?_____________________________
____

PATIENT HEALTH ASSESSMENT

Check as many that apply to you about your reason for visiting us today:

- ☐ Headaches
- ☐ Sports improvement
- ☐ Sleeplessness
- ☐ Balance issues
- ☐ Head injury
- ☐ Nutritional counseling
- ☐ Medication management
- ☐ Neurological assessment
- ☐ Other: ____________________

☐ If injury occurred, when? ____/____/________ ☐ Date symptoms started ____/____/________

☐ Another type of accident, trauma, or injury — Please explain what the incident was. Was it at work, home, or somewhere else?
____

☐ Neurological problem or disease — Please explain & include any prior diagnoses:
____

☐ Diagnostics — Please list previous diagnostic tests given for current complaints:
____

Were you referred to us by another health care provider? ☐ No ☐ Yes. If yes, who?____________________

Medications? *If you currently taking any, please list them. (If more than 12, please continue on the back of this form.)*

1. ____________ 5. ____________ 9. ____________
2. ____________ 6. ____________ 10. ____________
3. ____________ 7. ____________ 11. ____________
4. ____________ 8. ____________ 12. ____________

Herbs or Nutritional Supplements?
If you currently taking any, please list them. (If more than 9, please continue on the back of this form.)

1. ____________ 4. ____________ 7. ____________
2. ____________ 5. ____________ 8. ____________
3. ____________ 6. ____________ 9. ____________

Patient Name: ______________________

Date of Birth: _____/_____/_________

Do you have any known food, drug or environmental allergies? *If so, please list them. (If more than 6, please continue on the back of this form.)*

1. ______________ 3. ______________ 5. ______________

2. ______________ 4. ______________ 6. ______________

What is the most important thing we can do for you? ______________________

Quality of Life Rank. *Please circle where you rate your current quality of life.*

Poor 1 2 3 4 5 6 7 8 9 10 11 Excellent

Brain Health Rank. *How well do you think your brain is functioning?*

Terribly 1 2 3 4 5 6 7 8 9 10 11 Great

Have you seen anyone else for this condition? ☐ No. ☐ Yes. If yes, who? ______________

Have you lost work days because of this condition? ☐ No. ☐ Yes. If yes, How Many? ______________

How long has this problem been present? ☐ Weeks ________ ☐ Months ________ ☐ Years ________

Do you have any other complaints or concerns? ☐ No. ☐ Yes. If yes, what? ______________

What do you think is causing your present condition? ______________________

Indicate any other symptoms you think may be important. ______________________

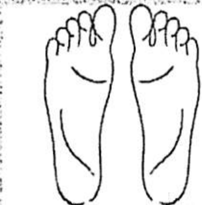
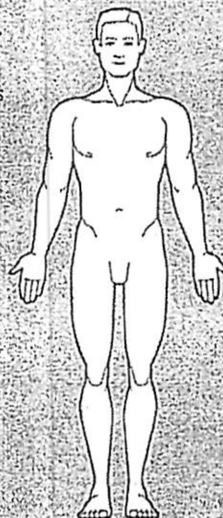
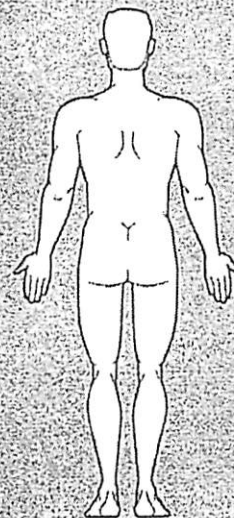
What are your 3 greatest concerns about your present state of health?

1. ______________ 2. ______________ 3. ______________

THIS AREA TO BE FILLED OUT BY THE DOCTOR

On the diagram, please mark the following symptoms, if you are experiencing them:

"//" stabbing pain
"B" for burning pain
"D" for dull pain
"A" for aching pain
"N" on or in areas where you have numbness
"T" in areas where you have tingling
"St" in areas where you feel stiffness
"Sw" in areas where you've had swelling
"C" in areas where you have cramps
"W" for weakness
"Tr" for tremor

Doctor's Notes. ______________________

Doctor's initials: ______

Patient Name: ____________________

Date of Birth: ______/______/________

Personal Health History

Please answer the following questions as completely as possible. *Continue answers on the back side of this form, if necessary.*

List all operations and surgeries you may have had, with dates *(month/year)* ____________________

____

List any major illness you have had, with dates *(month/year)* ____________________

____

Have you had any recent infections, colds, or flu? ❑ No ❑ Yes. When? ______/______/________

Please list any and all traumas or injuries you've ever had, with dates, from the simple to the serious. ____________________

____

Have you ever been diagnosed with a tumor, cancer, or neoplasia? ❑ No ❑ Yes. When? ______/______/________

Have you ever been diagnosed with diabetes? ❑ No ❑ Yes. When? ______/______/________

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? ❑ No ❑ Yes. When? ______/______/________

Have you ever had a stroke or heart attack? ❑ No ❑ Yes. When? ______/______/________

Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of:

Heart disease, stroke, cancer or diabetes? ❑ No ❑ Yes. Explain ____________________

Psychiatric diseases like depression, anxiety, schizophrenia, etc? ❑ No ❑ Yes. Explain ____________________

Neuropathies (nerve disease) or myopathies (muscle disease)? ❑ No ❑ Yes. Explain ____________________

Cancer? ❑ No ❑ Yes. Explain ____________________

Back or neck pain? ❑ No ❑ Yes. Explain ____________________

Any other known conditions? ❑ No ❑ Yes. Explain ____________________

The following questions help us determine levels of stress. Please answer as completely as possible.

Please indicate your familial status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

How many children do you have? ❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other: ____

What do you do for a living? ____________________ How many hours a week? ______

Do you have a second job? ____________________ How many hours a week? ______

Describe your work environment: ____________________

Describe your home life: ____________________

What is your highest level of education? ____________________

What are your hobbies? ____________________

Patient Name: ____________________

Date of Birth: _____/_____/_______

Personal Health History, continued

Please answer the following questions as completely as possible. *Social history*

Do you exercise?	❑ No ❑ Yes. What type and how often? ______
Do you currently use any tobacco products?	❑ No ❑ Yes. What kind, how often and how long? ______
Have you used tobacco products in the past?	❑ No ❑ Yes. What kind, how long, and when did you quit? ______
Do you drink alcoholic beverages?	❑ No ❑ Yes. What kind and how many a week? ______
Have you had issues with alcohol in the past?	❑ No ❑ Yes. How long ago and for how long? ______
Do you drink caffeinated beverages?	❑ No ❑ Yes. What kind and how many a day? ______
Do you drink sodas?	❑ No ❑ Yes. How many a day? ______
Do you currently use recreational drugs?	❑ No ❑ Yes. What type, how often, and how long? ______
Have you used recreational drugs in the past?	❑ No ❑ Yes. What kind, how long, and for how long? ______
Do you have any special dietary restrictions?	❑ No ❑ Yes. What type? ______
Are you sexually active?	❑ No ❑ Yes. Have you ever been diagnosed win an STD or VD? ❑ No ❑ Yes.
Do you currently see a chiropractor?	❑ No ❑ Yes.
When did you last see a chiropractor?	______
What were those visits for and how were the outcomes?	______

Review of Systems & Medical History

1. Are you currently experiencing any of the following symptoms, now or recently? *Cardiac screen*

❑ Chest pain	❑ Jaw pain	❑ Left arm pain
❑ Shortness of breath	❑ Excessive sweating without exertion	❑ Pale skin or pallor
❑ Blackouts	❑ Swelling in your left arm	❑ Light-headedness

2. Please check off any of the below symptoms that you are experiencing now or recently. *Stroke screen*

❑ Nausea	❑ Vomiting	❑ Difficulty with speaking
❑ Dizziness or vertigo	❑ Difficulty with swallowing	❑ Disequilibrium or feeling unsteady
❑ Double vision	❑ Feeling like you're going to fall	❑ Abnormal eye movements
❑ Numbness	❑ Abnormal sweating	❑ Headache

3. Have you noticed any of the following? *Cancer screen*

❑ Change in appetite	❑ Unexplained weight gain	❑ Recent fatigue
❑ Unexplained weight loss	❑ Recent fever	

Patient Name: ____________________

Date of Birth: ______/______/__________

Personal Health History, continued

Please mark below any of the conditions that apply to you, past or present. ❑ Past Condition ❑ Present Condition

Condition	Past	Present
Osteoporosis	❑	❑
Dislocated bones	❑	❑
Fractured bones	❑	❑
Bone infection (osteomyelitis)	❑	❑
Herniated disc	❑	❑
Scoliosis or other spinal curvature	❑	❑
Osteoarthritis or DJD	❑	❑
Rheumatoid arthritis	❑	❑
Other arthritis	❑	❑
Gout	❑	❑
Ankylosing spondylitis	❑	❑
Accidental fall	❑	❑
Mental or emotional disorder	❑	❑
Learning disability	❑	❑
Glaucoma	❑	❑
Heart palpitations (heart racing)	❑	❑
Swelling in legs or feet	❑	❑
Congestive heart failure	❑	❑
Chronic/frequent cough	❑	❑
COPD	❑	❑
Coughing up blood	❑	❑
Colon problems	❑	❑
Gall bladder trouble	❑	❑
Liver disease	❑	❑
Stomach/duodenal ulcer	❑	❑
Cirrhosis	❑	❑
Change in hat size	❑	❑
Change in skin mole	❑	❑
Acne	❑	❑
Hypertension	❑	❑
Seizures	❑	❑
Trouble concentrating	❑	❑
Paralysis	❑	❑
Twitching muscles	❑	❑
ADD or ADHD	❑	❑
Macular degeneration	❑	❑
Ringing in ears	❑	❑
Sinus problems	❑	❑
Mouth sores	❑	❑
Irregular heart beats	❑	❑
Experience passing out	❑	❑
Skipped heart beats	❑	❑
Congenital heart disease	❑	❑
Shortness of breath with activity	❑	❑
Short of breath at rest	❑	❑
Polyps	❑	❑
Diverticulitis	❑	❑
Change in nails	❑	❑
Eczema	❑	❑
Dermatitis	❑	❑
Pain in your face	❑	❑
Temporal arteritis	❑	❑
Fainting spells	❑	❑
Blurred vision	❑	❑
Double vision	❑	❑
Muscle cramping	❑	❑
Tremors (shaking)	❑	❑
Dyslexia	❑	❑
Asperger's syndrome	❑	❑
Sleep apnea	❑	❑
Cataracts	❑	❑
Arrhythmia	❑	❑
Heart murmur	❑	❑
Atherosclerosis/arteriosclerosis	❑	❑
Wheezing	❑	❑
Asthma	❑	❑
Gastric ulcers	❑	❑
Celiac Disease (Sprue)	❑	❑
Irritable bowel syndrome	❑	❑
Night sweats	❑	❑
Bruise easy	❑	❑
Psoriasis	❑	❑
Skin cancer	❑	❑
Loss of consciousness	❑	❑
Concussions	❑	❑
Head injury	❑	❑
Weak muscles of face	❑	❑
Autism (PDD or ASD)	❑	❑
Bed wetting	❑	❑
Retinopathy	❑	❑
High cholesterol	❑	❑
Scarlet fever	❑	❑
Rheumatic fever	❑	❑
Emphysema	❑	❑
Bronchitis	❑	❑
Hepatitis	❑	❑
Chrohn's disease	❑	❑
Diabetes	❑	❑
Hyperthyroidism	❑	❑
Hypothyroidism	❑	❑
Shingles	❑	❑
Herpes	❑	❑
Warts	❑	❑
Psychological issues	❑	❑
Depression	❑	❑
Prostate problems	❑	❑
Erectile dysfunction	❑	❑
Discharge from urethra	❑	❑
Gonorrhea	❑	❑
Bleeding disorder	❑	❑
Anemia	❑	❑
Allergies	❑	❑
Anxiety	❑	❑
Phobias	❑	❑
HPV/Genital warts	❑	❑
Breast discharge	❑	❑
Vaginal discharge	❑	❑
Breast lumps/soreness	❑	❑
Vascular disease	❑	❑
Varicose veins	❑	❑
Auto immune disease	❑	❑
Panic attacks	❑	❑
PTSD	❑	❑
OCD	❑	❑
Syphilis	❑	❑
Kidney problems or disease	❑	❑
Kidney stone	❑	❑
Difficulty urinating	❑	❑
Feelings of urgency to urinate	❑	❑
Leg pain with walking	❑	❑
Blood clots/phlebitis	❑	❑
Frequent colds or flus	❑	❑
Alcoholism	❑	❑
Cancer	❑	❑
Feelings of suicide	❑	❑
Eating disorders	❑	❑
Infrequent urination	❑	❑
Blood in urine	❑	❑
Painful urination	❑	❑
Awaken to urinate	❑	❑
Bladder infections	❑	❑
Other STD/VD	❑	❑
Venous insufficiency	❑	❑
Bruise easily	❑	❑
HIV/AIDS	❑	❑
Other *(please describe)*	❑	❑

____

____

____

Females only:

Is there any possibility that you are currently pregnant? ❑ No ❑ Yes

What was the date of your last menstrual period?

Date ______/______/__________

Patient Name: ______________________

Date of Birth: ______/______/________

Metabolic Assessment Form

The following questions and sections will guide staff clinicians in understanding your physiology. These forms are not meant for self diagnosis.

Please circle the appropriate number "0-3" on all questions below. 0 = least/never 3 = most/always

Category I *Colon health*

Question	Rating
Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II *Hypochlorhydria*

Question	Rating
Excessive belching, burping or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0 1 2 3

Category III *Hyporacidity*

Question	Rating
Stomach pain, burning or aching 1-4 hours after eating	0 1 2 3
Use antacids	0 1 2 3
Feel hungry and hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3

Category IV *Small intestine health*

Question	Rating
Roughage and fiber cause constipation	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category V *Biliary tract health*

Question	Rating
Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gall blader removed?	0 1 2 3

Category VI *Hypoglycemia*

Question	Rating
Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory/forgetful	0 1 2 3
Blurred vision	0 1 2 3

Category VII *Insulin resistance*

Question	Rating
Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal to or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category VIII *Adrenal fatigue*

Question	Rating
Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Patient Name: ____________________

Date of Birth: _______/_______/__________

Metabolic/Neurologic Assessment, continued

Please circle the appropriate number "0-3" on all questions below. 0 = least/never 3 = most/always

Category IX *Adrenal hyperfunction*

Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category X *Hypothyroid*

Tired/sluggish	0 1 2 3
Feel cold--hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals; excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI *Thyroid hyperfunction*

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XII *Pituitary hypofunction*

Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without symptoms	0 1 2 3

Category XIII *Pituitary hyperfunction*

Increased sex drive	0 1 2 3
Tolerance to sugars reduced	0 1 2 3
"Splitting"-type headaches	0 1 2 3

Category XIV (Males only) *Prostate health*

Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

Category XV (Males only) *Andropause*

Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Spells of mental fatigue	0 1 2 3
Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in past	0 1 2 3

Category XVI (Menstruating Females only)

Premenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than every 32 days)	0 1 2 3
Shortened menstrual cycle (less than every 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XVII (Menopausal Females only)

How many years have you been menopausal	0 1 2 3
Since menopause, do you ever have uterine bleeding?	0 1 2 3
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness or itching	0 1 2 3

Patient Name: ______________________

Date of Birth: ______/______/________

Neurologic Assessment Form

Please circle the appropriate number "0-3" on all questions below. 0 = least/never 3 = most/always

Section 1 *Brain endurance*

A decrease in attention span	0 1 2 3
Mental fatigue	0 1 2 3
Difficulty learning new things	0 1 2 3
Difficulty staying focused and concentrating for extended periods of time	0 1 2 3
Experiencing fatigue when reading sooner than in the past	0 1 2 3
Experiencing fatigue when driving sooner than in the past	0 1 2 3
Need for caffeine to stay mentally alert	0 1 2 3
Overall brain function impairs your daily life	0 1 2 3

Section 2 *Posture/movement compromise*

Twitching or tremor in your hands and legs when resting	0 1 2 3
Handwriting has gotten smaller and more crowded together	0 1 2 3
A loss of smell to foods	0 1 2 3
Difficulty sleeping or falling asleep	0 1 2 3
Stiffness in shoulders and hips that goes away when you start to move	0 1 2 3
Constipation	0 1 2 3
Voice has become softer	0 1 2 3
Facial expression that is serious or angry	0 1 2 3
Episodes of dizziness or light-headedness upon standing	0 1 2 3
A hunched over posture when getting up and walking	0 1 2 3

Section 3 *Memory/cognitive function*

Memory loss that impacts daily activities	0 1 2 3
Difficulty planning, problem solving, or working with numbers	0 1 2 3
Difficulty completing daily tasks	0 1 2 3
Confusion about dates, the passage of time, or place	0 1 2 3
Difficulty understanding visual images and spacial relationships (addresses and locations)	0 1 2 3
Difficulty finding words when speaking	0 1 2 3
Misplacement of things and inability to retrace steps	0 1 2 3
Poor judgment and band decisions	0 1 2 3
Disinterest in hobbies, social activities, or work	0 1 2 3
Personality or mood changes	0 1 2 3

Section 4 *Temporal lobe function*

Reduced function in overall hearing	0 1 2 3
Difficulty understanding language with background or scatter noise	0 1 2 3
Ringing or buzzing in the ear	0 1 2 3
Difficulty comprehending language without perfect pronunciation	0 1 2 3
Difficulty recognizing familiar faces	0 1 2 3
Changes in comprehending the meaning of sentences, written or spoken	0 1 2 3
Difficulty with verbal memory and finding words	0 1 2 3
Difficulty remembering events	0 1 2 3
Difficulty recalling previously learned facts and names	0 1 2 3
Inability to comprehend familiar words when read	0 1 2 3
Difficulty spelling familiar words	0 1 2 3
Monotone, unemotional speech	0 1 2 3
Difficulty understanding the emotions of others when they speak (nonverbal cues)	0 1 2 3
Disinterest in music and lack of appreciation for melodies	0 1 2 3
Difficulty with long-term memory	0 1 2 3
Memory impairment when doing the basic activities of daily living	0 1 2 3
Difficulty with directions and visual memory	0 1 2 3
Noticeable difference in energy levels throughout the day	0 1 2 3

Section 5 *Occipital lobe function*

Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects	0 1 2 3
Difficulty comprehending written text	0 1 2 3
Floaters or halos in your visual field	0 1 2 3
Dullness of colors in your field during different times of day	0 1 2 3
Difficulty discriminating similar shades of color	0 1 2 3

Section 6 *Frontal cortex function*

Difficulty with detailed hand coordination	0 1 2 3
Difficulty with making decisions	0 1 2 3
Difficulty with suppressing socially inappropriate thoughts	0 1 2 3
Socially inappropriate behavior	0 1 2 3
Decisions made based on desires, regardless of the consequences	0 1 2 3
Difficulty planning and organizing daily events	0 1 2 3
Difficulty motivating yourself to start and finish tasks	0 1 2 3
A loss of attention and concentration	0 1 2 3

Patient Name: ____________________

Date of Birth: ______/______/__________

Please circle the appropriate number "0-3" on all questions below. 0 = least/never 3 = most/always

Section 7 *Parietal lobe function*

Hypersensitivities to touch or pain	0 1 2 3
Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	0 1 2 3
Frequently bumping into the wall or objects	0 1 2 3
Difficulty with right-left discrimination	0 1 2 3
Handwriting has become sloppier	0 1 2 3
Difficulty with basic math calculations	0 1 2 3
Difficulty finding words for written or verbal communication	0 1 2 3
Difficulty recognizing symbols, words, or letters	0 1 2 3

Section 8 *Pontomedullary function*

Difficulty swallowing supplements or large bites of food	0 1 2 3
Bowel motility and movements slow	0 1 2 3
Bloating after meals	0 1 2 3
Dry eyes or dry mouth	0 1 2 3
A racing heart	0 1 2 3
A flutter in the chest or an abnormal heart rhythm	0 1 2 3
Bowel or bladder incontinence, resulting in staining your underwear	0 1 2 3

Section 9 *Indirect pathway involvement*

A decrease in movement speed	0 1 2 3
Difficulty initiating movement	0 1 2 3
Stiffness in your muscles (not joints)	0 1 2 3
A stooped posture when walking	0 1 2 3
Cramping of your hand when writing	0 1 2 3

Section 10 *Direct pathway involvement*

Abnormal body movements (such as twitching legs)	0 1 2 3
Desires to flinch, clear your throat, or perform some type of movement	0 1 2 3
Constant nervousness and a restless mind	0 1 2 3
Compulsive behaviors	0 1 2 3
Increased tightness and tone in specific muscles	0 1 2 3

Section 11 *Cerebellar function*

Difficulty with balance, or balance that is noticeably worse on one side	0 1 2 3
A need to old the handrail or watch each step carefully when going down stairs	0 1 2 3
Episodes of dizziness	0 1 2 3
Nausea, car sickness, or seasickness	0 1 2 3
A quick impact after consuming alcohol	0 1 2 3
A slight hand shake when reaching for something	0 1 2 3
Back muscles that tire quickly when standing or walking	0 1 2 3
Chronic neck or back muscle tightness	0 1 2 3

Section 12 *Brain circulation compromise*

Low brain endurance for focus and concentration	0 1 2 3
Cold hands and feet	0 1 2 3
Must exercise or drink coffee to improve brain function	0 1 2 3
Poor nail health	0 1 2 3
Fungal growth on toenails	0 1 2 3
Must wear socks at night	0 1 2 3
Nail beds are white instead of pink	0 1 2 3
The tip of the nose is cold	0 1 2 3

Section 13 *Sugar metabolism*

Irritable, nervous, shaky, or light-headed between meals	0 1 2 3
Feel energized after meals	0 1 2 3
Difficulty eating large meals in the morning	0 1 2 3
Energy level drops in the afternoon	0 1 2 3
Crave sugar and sweets in the afternoon	0 1 2 3
Wake up in the middle of the night	0 1 2 3
Difficulty concentrating before eating	0 1 2 3
Depend on coffee to keep going	0 1 2 3

Section 14 *Peripheral utilization of sugar*

Fatigue after meals	0 1 2 3
Sugar and sweet cravings after meals	0 1 2 3
Difficulty losing weight	0 1 2 3
Increased frequency of urination	0 1 2 3
Difficulty falling asleep	0 1 2 3
Increased appetite	0 1 2 3

Section 15 *Stress & brain function*

Always have projects and things that need to be done	0 1 2 3
Never have time for yourself	0 1 2 3
Not getting enough sleep or rest	0 1 2 3
Difficulty getting regular exercise	0 1 2 3
Feel that you are not accomplishing your life's purpose	0 1 2 3

Section 16 *Essential fatty acids*

Dry and unhealthy skin	0 1 2 3
Dandruff or a flaky scalp	0 1 2 3
Consumption of processed foods that are bagged or boxed	0 1 2 3
Consumption of fried foods	0 1 2 3
Difficulty consuming raw nuts or seeds	0 1 2 3
Difficulty consuming fish (not fried)	0 1 2 3
Difficulty consuming olive oil, avocados, flax seed oil, or natural fats	0 1 2 3

Patient Name: ______________________

Date of Birth: ______/______/__________

Please circle the appropriate number "0-3" on all questions below. 0 = least/never 3 = most/always

Section 17 *Brain gut axis*

Difficulty digesting foods	0 1 2 3
Constipation or inconsistent bowel movements	0 1 2 3
Increased bloating or gas	0 1 2 3
Abdominal distention after meals	0 1 2 3
Difficulty digesting protein rich foods	0 1 2 3
Difficulty digesting starch rich foods	0 1 2 3
Difficulty swallowing supplements or large bites of food	0 1 2 3
Abnormal gag reflex	Yes or No

Section 18 *Brain immune axis*

Brain fog (unclear thoughts or concentration)	Yes or No
Pain and inflammation	Yes or No
Noticeable variation in mental speed	Yes or No
Brain fatigue after meals	0 1 2 3
Brain fatigue after exposure to chemicals, scents, or pollutants	0 1 2 3
Brain fatigue when the body is inflamed	0 1 2 3

Section 19 *Gliadins*

Grain consumption leads to tiredness	0 1 2 3
Grain consumption makes it difficult to focus and concentrate	0 1 2 3
Feel better when bread and grains are avoided	0 1 2 3
Grain consumption causes the development of any symptoms	0 1 2 3
A 100% gluten-free diet	Yes or No

Section 20 *Intestinal barriers*

A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease	Yes or No
Family members who have been diagnosed with an autoimmune disease	Yes or No
Family members who have been diagnosed with celiac disease or gluten sensitivity	Yes or No
Changes in brain function with stress, poor sleep, or immune activation	0 1 2 3

Section 21 *Serotonin compromise*

A loss of pleasure in hobbies and interests	0 1 2 3
Feel overwhelmed with ideas to manage	0 1 2 3
Feelings of inner rage or unprovoked anger	0 1 2 3
Feelings of paranoia	0 1 2 3
Feelings of sadness for no reason	0 1 2 3
A loss of enjoyment in life	0 1 2 3
A lack of artistic appreciation	Yes or No
Feelings of sadness in overcast weather	0 1 2 3
A loss of enjoyment in favorite foods	0 1 2 3
A loss of enjoyment in friendships and relationships	0 1 2 3
Inability to fall into deep, restful sleep	0 1 2 3
Feelings of dependency on others	0 1 2 3
Feelings of susceptibility to pain	0 1 2 3

Section 22 *Dopamine compromise*

Feelings of worthlessness	0 1 2 3
Feelings of hopelessness	0 1 2 3
Self-destructive thoughts	0 1 2 3
Inability to handle stress	0 1 2 3
Anger and aggression while under stress	0 1 2 3
Feelings of tiredness, even after many hours of sleep	0 1 2 3
A desire to isolate yourself from others	0 1 2 3
An unexplained lack of concern for family and friends	0 1 2 3
An inability to finish tasks	0 1 2 3
Feelings of anger for minor reasons	0 1 2 3

Section 23 *Acetylcholine compromise*

A decrease in visual memory (shapes and images)	Yes or No
A decrease in verbal memory	0 1 2 3
Occurrence of memory lapses	0 1 2 3
A decrease in creativity	0 1 2 3
A decrease in comprehension	0 1 2 3
Difficulty calculating numbers	0 1 2 3
Difficulty recognizing objects and faces	0 1 2 3
A change in opinion about yourself	0 1 2 3
Slow mental recall	0 1 2 3

Section 24 *Catecholamines compromise*

A decrease in mental alertness	0 1 2 3
A decrease in mental speed	0 1 2 3
A decrease in concentration quality	0 1 2 3
Slow cognitive processing	0 1 2 3
Impaired mental performance	0 1 2 3
An increase in the ability to be distracted	0 1 2 3
Need coffee or caffeine sources to improve mental function	0 1 2 3

Section 25 *GABA compromise*

Feelings of nervousness or panic for no reason	0 1 2 3
Feelings of dread	0 1 2 3
Feelings of a "knot" in your stomach	0 1 2 3
Feelings of being overwhelmed for no reason	0 1 2 3
Feelings of guilt about everyday decisions	0 1 2 3
A restless mind	0 1 2 3
An inability to turn off the mind when relaxing	0 1 2 3
Disorganized attention	0 1 2 3
Worry over things never thought about before	0 1 2 3
Feelings of inner tension and inner excitability	0 1 2 3

Patient Name: ______________________

Date of Birth: ______/______/______

Are there any other concerns or interests you have about your health that you would like us to address?
You may describe any other concerns or questions in this space:

____

____

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____

Patient Authorization

Thank you for taking the time to fill out this questionnaire. This information is important to the doctor obtaining an accurate clinical picture so as to make an appropriate diagnosis and treatment plan. Please sign the below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at Advanced Performance and Rehab. Any disclosure is outlined in our privacy policies.

______________________________ ______________

Patient's (or guardian's) signature Date

______________________________ ______________

Signature of translator or person assisting you (if any) Date

____

Printed name

Doctor's Notes. ______________________________

____

____

____

____

____

____ Doctor's initials: _____

532 Old Short Hills Road • Short Hills, NJ 07078 • 973-467-9011

Consent to Allow Treatment

I have received information about my condition and proposed chiropractic treatment program as well as alternative courses of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle strains and joint sprains, fractures, dislocations, disc injuries and strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments which he/she feels at the time, based upon the facts then known, is in my best interest.

My doctor has responded to all my request for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its consent. By signing below, I consent to treatment.

Print Patient Name:____

Print Parent/Guardian Name (if applicable): ___________________________

Patient Signature:__________________________________ Date:__________

Parent/Guardian Signature:___________________________ Date: _________

Doctor Signature: __________________________________ Date: _________

FINANCIAL AGREEMENT

Dear Patient:

We will attempt to provide you with information necessary to determine the type of care you will require and the financial information you may need to determine how you wish to handle your financial obligation to our office.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

Verification of Benefits / Authorizations / Notice of Collection Action

APRC will try and verify my insurance benefits prior to my appointment. However, I understand I am solely responsible for knowing the benefits my insurance plan provides. Furthermore, it is my responsibility to ensure APRC has my current insurance coverage information and a copy of my valid identification card on file at all times in order to verify my coverage and ensure timely and accurate processing of all claims.

I understand all co-payments are due at the time services are rendered and I am responsible to pay any additional amounts due in full; including, but not limited to, annual deductibles, co-insurance, and any other charges denied for payment by my insurance company for any reason.

In the event my account balance is unpaid for longer than 30 days, I agree to pay a finance charge of 1.5% per month on all overdue charges. Additionally, should my account remain delinquent and/or be turned over to a collection agency, I am responsible to pay for any and all additional fees incurred (i.e. late fees, collection agency fees, attorney fees, court fees, etc.) not to exceed 50% of the balance due.

NOTE: The Advanced Performance and Rehabilitation Center will refund any overpayments made to us upon receipt of insurance payment.

THERE IS A 24 HOUR CANELLATION POLICY. A $60.00 CHARGE WILL BE BILLED FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELED WITHIN 24 HOURS PRIOR TO THE SCHEDULED TIME.

THERE IS A $50.00 ADDITIONAL CHARGE FOR ANY EMERGENCY VISITS OR OFFICE VISITS OUTSIDE OUR NORMAL OFFICE HOURS.

I AGREE THIS AUTHORIZATION SHALL REMAIN VALID UNLESS I RESIND IN WRITING.

PRINT PATIENT NAME: ______________________________________ Date: _____________

GUARANTOR/PATIENT SIGNATURE: ____

Advanced Performance and Rehabilitation Center, LLC
532 Old Short Hills Road
Short Hills, NJ 07078
973-467-9011 • 973-467-9012 (Fax)

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. ***Please review it carefully.***

Under new federal regulations, Advanced Performance and Rehabilitation Center, LLC along with all health care providers are required and obligated to maintain the privacy of your protected health information (PHI). This information may identify you & relates to your health, your conditions, and health care related services whether physical or mental.

This notice describes how we may use and disclose PHI information to other parties for the purpose of treatment, dispensing medications, and disclosing information to your health care provider or your physician via mail, phone or directly. We may use and disclose medical information so that services received at Advanced Performance and Rehabilitation Center, LLC may be billed to and payment may be collected from your insurance company, pharmacy benefit managers (PBM) or a third party.

We ***may*** use or disclose your PHI in accordance with the privacy rules without obtaining your consent or authorizations in the following instances. Contracted business associates rendering services for us in which PHI must be disclosed in order to perform their job (such as third party billing of your prescription drug benefits). Our business associates are required to protect your PHI in accordance to law. Discussions with individuals involved with your care or payment of your care if deemed appropriate by the health care professional. F.D.A. requirements to prevent serious health or safety threats to the public. Health oversight authorized by law including audits, investigations and inspections required for licensure and government monitoring of health care programs and civil rights issues. Workman's compensations claims. *As required by law.*

We are permitted to use and disclose PHI for the following purposes *In accordance to law*: Coroners, Medical & Funeral Directors to carry out their functions, Organ or Tissue procurement organizations, Judicial or administrative proceedings, law enforcement purposes, governmental authorities, and national security. Victims of abuse, neglect and domestic violence to protective service agencies. Military authorities.

You have the right in writing, to request restriction of certain uses & disclosures of PHI with regards to the nature of your treatment, payment, and health care operations to a family member, relative or representative. We are, however, not required by federal law to comply. If you request a copy of your PHI, you have the right to send it to a different location and by alternate means.

Further information or questions relating to your privacy rights may be addressed to *Dr. Jason Levy* (privacy officer). Please address any complaints regarding your privacy rights to our privacy officer or with the secretary of health & human services.

To be assured you received or read this notice *please sign and return* this notice at your earliest convenience.

*Signature*________________________________*print name*_____________________________________

Recipient___Authorized Rep.___Family Member___Care Giver___

Advanced Performance and Rehabilitation Center, LLC
532 Old Short Hills Road
Short Hills, NJ 07078
973-467-9011 • 973-467-9012 (Fax)

Health Insurance Portability & Accountability Act (HIPAA)

*** PRIVACY NOTICE ACKNOWLEDGEMENT ***

Under new federal regulations, **Advanced Performance and Rehabilitation Center, LLC** along with all health care providers are required to maintain the privacy of your **protected health information "PHI."**

This notice describes how we may use and disclose your PHI.

To be assured you received and/or read this notice, please sign:

I have received and/or read Advanced Performance and Rehabilitation Center's Privacy Notice.

Signature ____ Date ________________

Print Name ____

Recipient _____ *Authorized Rep.* ____ *Family Member* ____ *Care Giver* ____

Emergency Contact Form

Patient Name: ____________________

Phone Number ____________________

IMPORTANT: I am filling out this form for the first time: ____YES ____NO, I am updating my information

Special Instructions:

In the event of a medical emergency, are there any emergency procedures or restrictions on medications of which emergency personnel should be aware? If yes, please explain.

____

Emergency Contacts:

Primary Contact in case of emergency:

Name ____________________ Relationship ____________________

Address ____________________ Phone Number ____________________

____________________ Alternate Phone Number ____________________

Secondary Contact in case of emergency:

Name ____________________ Relationship ____________________

Address ____________________ Phone Number ____________________

____________________ Alternate Phone Number ____________________

Physician Contact:

Doctor's Name ____________________ Address ____________________

Phone Number ____________________ ____________________

Patient Authorization

I have voluntarily provided the above contact information and authorize APRC and its representatives to contact any of the above individuals on my behalf in the event of an emergency.

____________________ ____________________

Patient signature *Date*

Directions to APRC

532 Old Short Hills Road, Short Hills, NJ 07078
973-467-9011

From Millburn: Take Old Short Hills Road towards St. Barnabas Hospital. Cross over South Orange Avenue and continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right), just before the brick garden apartments. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From JFK Parkway: Take JFK Parkway away from the mall, towards Livingston. Make a right at the first traffic light onto South Orange Avenue. Continue on South Orange Avenue through 2 lights, at the first light you'll see an Exxon gas station on your left & Tutor Time on your right. Continue to the 2nd traffic light, which is Old Short Hills Road, and turn left at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From the Livingston Mall on South Orange Avenue: Take South Orange Avenue through 2 lights, at the first light you'll see an Exxon gas station on your left & Tutor Time on your right. Continue to the 2nd traffic light, which is Old Short Hills Road, and turn left at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From South Orange: Take South Orange Avenue to Old Short Hills Road. Make a right at the light onto Old Short Hills Road. Continue for approximately ¼ mile. We are a home office on the right, one home office past a street called Puritan (on your right). The office is just before the brick garden apartments on your right. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From West Orange: Take Northfield Avenue to the traffic light at Old Short Hills Road. You will see the Livingston Diner on the far left corner, the Northfield Cleaners on the closest corner on the left, and Master Pizza on your right. Make a left onto Old Short Hills. Continue on Old Short Hills Road, through approximately 3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From Livingston (Northfield Avenue): Make a right onto Old Short Hills Road. Continue on Old Short Hills Road, through approximately 3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.

From 280 East: Take 280 East to exit 6A (Laurel Avenue). Follow the blue and blue "H" signs for St. Barnabas Hospital. Bare left at the fork in the road onto Shrewsberry Drive. Continue straight on Shrewsberry Drive. Cross over Mt. Pleasant Avenue (Route 10). Shrewsberry Drive will change its name to East Cedar Lane. Just continue straight. Cross over Northfield Avenue and continue to go straight. The road merges into Old Short Hills Road. Continue on Old Short Hills Road, through approximately 2-3 traffic lights; pass St. Barnabas Hospital on your right. We are the 1st home office on the left just past the brick garden apartments on your left. You'll see a black sign. The number is 532. There is a side parking lot and side entrance.