ADVANCED PERFORMANCE AND REHABILITATION CENTER

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

Name: _____ Age: _____ Today's Date: _____

Address: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Social Security # _____ Male ___ Female ___ Birth Date _____

Occupation/Employer's Name & Address _____

Single _____ Married _____ Divorced _____ Widowed _____ E-mail Address _____

a.p.r.c.

ADVANCED PERFORMANCE & REHABILITATION CENTER

CHIROPRACTIC PODIATRY

Michael Teytelbaum, DC, ART

Metabolic Assessment Form

Name: ______________________ Age: ______ Sex: _____ Date: ____________

PART I

Please list the 5 major health concerns in your order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

PART II

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

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief 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

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

Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, 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

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 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

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 gallbladder removed		Yes	No	

Category VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded 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

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 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

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

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition
For nutritional purposes only

Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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				
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 gain 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 or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI				
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				
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				
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)				
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 evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning 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
Decrease in 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 the past	0	1	2	3

Category XVI (Menstruating Females Only)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
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 breakouts	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? _____				
Since menopause, do you ever have uterine bleeding?	Yes	No		
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

How many alcoholic beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

How many caffeinated beverages do you consume per day? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you work out? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke? _____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Health Questionnaire (NTAF)

Name: _____ Age: _____ Sex: _____ Date: _____

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

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

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Financial Agreement:

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 deductible, co-insurance, and any other charges denied for payment by my insurance company for any reason.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

Should my account become delinquent and/or be turned over to a collection agency, I am responsible to pay for any all additional fees incurred (ie: late fees, collection agency fees, attorney fees, court fees, etc) not to exceed 50% of the balance due.

Authorization for Care:

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand, 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 judgement during the course of my treatments which he/she feels at the time, based upon the facts then knows, is in my best interest.

Agreement:

My signature below signifies my agreement for payment in full on a cash basis if I have not provided all the necessary documents and information by the time of the second visit.

I have read and agree to the above statement.

Signature

Date Signed

_____

Printed Name

_____

Email

_____

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 this information. **Please review it carefully. THIS IS AN OVERVIEW OF YOUR RIGHTS; A DETAILED COPY IS AVAILBLE AT YOUR REQUEST.**

YOUR RIGHTS-You have the right to:

- Get a copy of your paper or electronic record: According to NJ law code 8.43G-4.1 you must submit a written request and we are required to provide you with a copy within 30 days.
- Correct your paper or electronic medical record
- Request confidential communication: You may inform us of your preferred method such as Home Phone, Cell Phone or Email. Please advise us whether a detailed message is permissible.
- Ask us to limit the information we share: we may say "No" if it would affect your care. You can ask us not to share out-of-pocket payments with your insurer and we will agree unless a law requires us to do so.
- Get a list of those whom we've shared your information outside the purposes of treatment, payment and at your request. We reserve the right to charge a reasonable fee for more than one copy within a 12 month period.
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated: You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/provacy/hipaa/complaints/.**
- Get a copy of Privacy Notice

YOUR CHOICES- You have some choices in the way that we use and share information

If you are unable to tell us your preference we may share your information if we believe it is in your best interest.

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

The following are cases in which we **NEVER** *share your information*

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

We may contact you for fund raising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES- We may use and share information as we:

- Treat you: we may share your information with other medical professionals treating you
- Run our organization
- Bill for services
- Help with public health and safety issues: To view a list of scenarios in which the law requires our cooperation go to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**
- Do research
- Comply with the law
- Respond to organ and tissue requests
- Work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action: Only in cases of a court order or subpoena

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs the may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and provide a copy of it
- We will not share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available upon request, in our office, and on our website.

Signature_____Print Name _____Date_____

APRC HIPAA Officer
Michelle Kelly
973-467-9011 • Admin@APRCNJ.com