Welcome Dr. Joel J. Angyal,D.C.,D.A.A.P.M

510 Anderson Avenue

Cliffside Park, NJ 07010

Patient Information:

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| --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_ □ Male *□*Female  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St.\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_  Home# ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell# ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work# ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Social Security#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_  Marital Status: □Single □Married □Divorced □Widowed EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **How Did you hear about our office:** □Ins. Co. □Google □Gothem Diner □Advertising □Attorney  □ Other – Name of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- |
| Are you Pregnant? □Yes □NO  What is your Height? \_\_\_\_\_\_\_\_ What is your weight?\_\_\_\_\_\_\_\_  Are you taking any of the following medication?  □Pain killers □muscle □relaxers □tranquilizers  □Stimulants □blood thinner □nerve pills |

In Case of Emergency

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| --- |
| Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Who is your Primary Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you ever been treated by a Chiropractor before? □Yes □No  Did You See another doctor for this condition? □Yes □No if so, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

TURN OVER PAGE

Health History

Have you been tested positive for Covid? □ Yes □No If so, did you have the antibodies test? □ Yes □No

List All Medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any medical conditions or surgeries you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any past accidents with dates (car accidents, slip & falls, sports) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following diseases/medical conditions?

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| Y / N – Heart Attach/Stroke Y / N – Heart Surgery/Pacemaker Y / N – Heart Murmur  Y / N – Congenital Heart defect Y / N – Mitral Valve Prolapse Y / N – Rheumatic Fever  Y / N – Sinus Problems Y / N – Thyroid Y / N – Hepatitis  Y / N – HIV / Aids Y / N – Diabetes/Tuberculosis Y / N – Cancer  Y / N – Asthma Y / N – Fainting/Seizures/Epilepsy Y / N – Anemia  Y / N – Psychiatric Problems Y / N – Shingles Y / N – Kidney Problems  Y / N – Arthritis Y / N – Difficulty Breathing Y / N – Artificial Bones/Joints  Y / N – High Blood Pressure Y / N – Hernia Y / N – Gastro Problems |

List any family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect info can be dangerous to my health. It is my responsibility to inform the doctor’s office of any changes in my medical status.

I also give permission to Dr. Angyal’s office to submit my medical information to the insurance company upon their request. □ Yes □No

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Patient Signature Date