SOUTH JERSEY
NEUROPATHIC PAIN SOLUTION

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ DOB: _____ Age: _____ Height: _____ Weight: _____

Male☐ Female☐ Single☐ Married☐ Divorced☐ # of Children: _____ Spouse (or Parent): _____

What is the name of your family physician? _____ What city are they located in? _____

Doctors Seen Before for this condition: _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptom, etc.)

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

Currently or in the past have you ever experienced any of these complaints while working? _____ If yes, please describe what activities at work that may be causing you to experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? If yes, please explain: _____

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of the injury? _____

Do you have an attorney for this work injury? _____Yes _____ No If yes, who is your attorney? _____

Have you been involved in a car accident in the last 12 months? _____Yes No If yes, when? _____

Do you have an attorney for this car injury? _____Yes _____No If yes, who is your attorney? _____

How many other passengers were in the car with you during the car accident? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

Have you ever had any surgeries or hospitalizations? _____ If yes, what is the date of injury? _____

Please list any current or past injuries and illnesses not listed above: _____

Please list all medications (prescription or non-prescription) you are currently taking: ☐ Aspirin/Tylenol ☐ Pain Killers

☐ Muscle Relaxers ☐ Insulin ☐ Tranquilizers ☐ Birth Control Pills ☐ Others _____

Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's Health Insurance (If applicable) _____ Policyholder _____

Spouse's Health Insurance Claims address _____ Policy Number _____

Health Conditions

Please check any conditions that currently exist or have existed in the past:

For women:

Are you pregnant?	**_____Yes _____ No**
Are you nursing?	**_____Yes _____ No**
Do you experience painful periods?	**_____Yes _____ No**
Do you have irregular cycles?	**_____Yes _____ No**
Are you taking birth control?	**_____Yes _____ No**
Do you have breast implants?	**_____Yes _____ No**

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all expenses incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services directly to the provider for services rendered.

_____ _____

Patient's Signature Date Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account:

_____ Patient _____ Spouse _____ Parent

_____ Worker's Comp _____ Auto Insurance _____ Medicare

_____ Medicaid _____ Personal Health Insurance

Ownership of X-Ray Films: It is understood and agreed that the payments to the Doctor for X-Rays are for examination of X-Rays only. The X-Ray negatives will remain the property of this office. All X-Rays will be kept on the file where they may be seen at any time while I am patient of this office.

CONSENT TO TREATMENT OF MINOR

I/we, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, to be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgement, deem advisable. These authorizations shall remain effective until _____ , 20 , unless sooner revoked in writing delivered to the agent(s) noted above.

_____

Parent/Legal Guardian/Person having legal custody (circle relationship) Date

Provider Privacy Policy

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.

USES AND DISCLOSURES

Treatment: Your health information may be disclosed to other health care professionals for the purpose of evaluating your health and providing treatment. For example, customer service information may be available to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the daily operations and management of Supplier. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Marketing: We may use your oral or written testimony, with your permission, for marketing the benefits of our office.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Information about treatments: Your health information may be used to send you information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual rights: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of our protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Supplier's Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect protected health information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to our records by contacting South Jersey Neuropathic Pain Solution. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about your privacy practices, you can do so by sending a letter outlining your concerns to:

South Jersey Neuropathic Pain Solution
100 West Old Marlton Pike
Marlton, NJ 08053

If you believe that your privacy right have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact person: The name and address of the person you may contact for further information concerning our privacy practices is:

Robert C. Dees, DC
1 Peters Ave, Suite 101
Pleasanton, CA 94566
(925) 393-0100

Signature	Date	Print Name

SOUTH JERSEY NEUROPATHIC PAIN SOLUTION

Name: _____ Date: _____

This questionnaire has been designed to give your us information as to how the pain has affected your ability to manage in everyday life. Please answer every question by placing a check mark in the one line that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but please mark only the box that most closely describes your current condition.

Pain Intensity
- I can tolerate the pain I have without having to use pain medication
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication has no effect on my pain.

Personal Care (e.g., washing, dressing)
- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on table).
- Pain prevents me from lifting heavy weights, but I can manage to lift light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Walking
- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile (1 mile = 1.6km).
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

Sitting
- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Standing
- I can stand as long as I want without increased pain.
- I can stand as long as I want, but it increases my pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Sleeping
- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take pain medication, I sleep less than 6 hours
- Even when I take pain medication, I sleep less than 4 hours
- Even when I take pain medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Social Life
- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

Traveling
- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the physician/therapist or hospital.

Employment/Homemaking
- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain, but I can still perform all tha tis required of me.
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

_____SS

Source: Fritz JM, Irrgang JJ. A comparison of a modified Oswestry Low Back Pain Disability Questionnaire and the Quebec Back Pain Disability Scale. Physical therapy. 2001;81:776-788

(Please circle as many that apply)

1. How have you taken care of your health in the past?
   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic treatment
   i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not work get worse
   f. Did not work very long
   g. Still trying
   h. Confused

3. How have others been affected by your health condition?
   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self Esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

5. Are there health conditions you are afraid this might turn into?
    a. Family health problems
    b. Heart disease
    c. Cancer
    d. Diabetes
    e. Arthritis
    f. Fibromyalgia
    g. Depression
    h. Chronic Fatigue
    i. Need Surgery

How has your health condition affected your job, relationships, finances, family or other activities? Please give examples: _____

_____

What has that cost you? (Time, money, happiness, freedom, sleep, promotion, etc.) give 3 examples:

_____

_____

What are you most concerned with regarding your problem? _____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

_____

What would be different/better without this problem? Please be specific

_____

_____

What do you desire most to get from working with us? _____

_____

SOUTH JERSEY
NEUROPATHIC PAIN SOLUTION

The Calmare® device is a U.S. FDA 510(k)-cleared and European CE mark-certified pain therapy medical device for the non-invasive treatment of chronic neuropathic and oncologic pain. Treatment using the Calmare device avoids the harmful, potential fatal, adverse side effects and addictive properties linked to narcotic pain killers.

The Calmare® device has been used to successfully treat over 4,000 patients worldwide, where it has been shown to be effective in treating neuropathic and oncologic pain. The device is currently being used in the US at these key teaching hospitals:
-Virginia Commonwealth University's Massey Cancer Center
-Paul Carbone Cancer Center at University of Wisconsin-Madison

How it Works

The Calmare® device uses a biophysical rather than a biochemical approach. A 'no-pain' message is transmitted to the nerve via disposable surface electrodes applied to the skin in the region of the patient's pain. The perception of pain is cancelled when the no-pain message replaces that of pain, by using the same pathway through the surface electrodes in a non-invasive way. Regardless of pain intensity, a patient's pain can be completely removed for immediate relief.
Maximum benefit is achieved through follow-up treatments. The patient may be able to go for extended periods of time between subsequent treatments while experiencing significant pain control and relief. The period of time between treatments depends on the underlying cause and severity of the pain in addition to other factors.

Who it works for

Chemotherapy-Induced Peripheral Neuropathy (CIPN)
Chronic Cancer Pain
Failed Back Surgery Syndrome (FBSS)
Sciatic and Lumbar Pain
Phantom Limb Syndrome
Postherpetic Neuralgia (PHN)
Post-Surgical Neuropathic Pain
Brachial Plexus Neuropathy
Low Back Pain (LBP)
Chronic Neuropathic Pain
Residual Shingles Pain

Benefits

Non-Invasive Painless
Immediate Pain Relief
Ongoing Pain Control
No adverse side effects of opiods and other drugs

CALMARE®
Making pain-free a reality

CONSENT AND RELEASE FOR

CALMARE® SCRAMBLER PAIN THERAPY TREATMENT

By executing this CONSENT AND RELEASE, the undersigned agreeing to use, or have used upon him/her, the Calmare® Scrambler Pain Therapy Treatment Medical Device ("Calmare®" or "Medical Device"), a treatment that through the use of disposable surface electrodes imparts electrical impulses, referred to as artificial neurons, to the body for the purpose of the stimulation of, and communication through, the C-fiber of the nerves to affect how the body detects, interprets or feels pain or painful sensations. The Calmare® has Federal Food and Drug Administration (FDA) clearance for use within the United States. In addition, Calmare® has received European Commission (EC) approval for use in Europe.

CONTRAINDICATIONS: You should not have the treatment if you suffer from and/or have any of the following contraindications including symptoms, conditions, or devices:

- You have a pacemaker or automatic defibrillator
- You have a aneurysm clip, vena cava clips, or skull plates (mental implants for orthopedic repair, e.g. pins, plates, joint replacements are allowed)
- You have any implanted device such as a spinal nerve stimulator or implanted drug delivery system
- You are, or could be pregnant and/or breast feeding
- You have a history of epilepsy, brain damage, use of anticonvulsant medications for purposes other than pain control
- You have a history of, or have been treated for myocardial infarction or ischemic heart disease within the past six months
- You have, or believe that you may have, severe heart arrhythmia or any form of equivalent heart disease
- You have a condition that would require electrode placement on front of the neck (carotid sinus region) or head
- You are in active withdrawal from drugs and/or alcohol
- You have wounds or skin irritation in areas where the electrodes are required to be placed
- You are allergic to latex
- You have a history of a previous intolerance to transcutaneous electronic nerve stimulation

The use of the medical device could lead to injury or even death due to the presence of any of the above listed contradictions. You hereby represent and warrant that you do not suffer from or have any of the above identifying contradictions including symptoms, conditions, or devices.

PRECAUTIONS: The primary care provider should review and consider the risk vs. benefit ration for patients considering treatment with this medical device under the following situations, conditions, or devices:

- You have pain originating in the central nervous system
- Because this device is capable of delivering a charge per pulse of 25 micro coulombs or greater, you should not place electrodes in a trans-thoracic position (may cause cardiac arrhythmia)
- You are prone to skin irritation (isolated cases have occurred)
- You have not had a clear diagnosis of neuropathic pain
- You are connected to other electronic monitoring equipment (ECG monitor) – may not operate properly with the medical device is in use
- You are on neuroleptic medications (examples: carbamazepine, pregabalin, gabapentin) which appear to "interfere with treatment efficacy" and "decrease longevity" of no-pain post treatment protocol

YOUR VOLUNTARY USE OF THIS MEDICAL DEVICE IS DONE AT YOUR OWN RISK AND WITH FULL KNOWLEDGE OF THE ABOVE, AS WELL AS THE RISKS INCUMBENT WITH ANY MEDICAL DEVICE. YOU HEREBY RELEASE COMPETITIVE TECHNOLOGIES, INC. (AKA "CTTC" OR "CTT") AND THEIR RESPECTIVE AFFILIATES, EMPLOYEES, DIRECTORS, OFFICERS, SHAREHOLDERS, AGENTS AND REPRESENTATIVES, INCLUDING AND WITHOUT LIMITATION, CONDITIONS, DISEASES AND ANY OTHER HARM THAT YOU MAY SUFFER OR COME TO SUFFER OR COME TO SUFFER AS A RESULT OF YOUR USE OF THE MEDICAL DEVICE. IN ADDITION, YOU HEREBY WAIVE ANY AND ALL CLAIMS THAT YOU MAY HAVE AGAINST THE RELEASED PARTIES, AND COVENANT NOT TO SUE THE RELEASED PARTIES, IN CONNECTION WITH, ARISING FROM OR RELEATING TO YOUR USE OF THE MEDICAL DEVICE.

By executing this document below, in addition to agreeing to all of the above, you represent and warrant that you are of legal age to enter into a legally binding agreement.

PATIENT

I have read and understand this form and I voluntarily authorize and consent to the treatment. My signature below acknowledges that I have been provided with the information necessary to make an informed decision and wish to proceed with the proposed treatment/procedure. I further acknowledge that I have had the opportunity to discuss the proposed treatment, concerns or questions with my referring physician or medical practitioner including risks, benefits and alternative treatments

PRINTED Patient Name Patient Signature Date

I verify that I have explained the information contained in this document to the patient. It is my opinion that the person granting consent fully understands all subjects discussed and medically meets the criteria for treatment.

PRINTED Physician Name Physician Signature Date