BODYWISE CHIROPRACTIC PLLC

PLEASE TELL US ABOUT YOU!

TODAY'S DATE ____/____/______

NAME ______________________ MALE ___ FEMALE ___ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED ___

HOW YOU PREFER TO BE ADDRESSED ______________ BIRTHDATE ____/____/______ AGE ________

SOCIAL SECURITY # _____-_____-______ EMAIL ADDRESS ______________________

STREET ADDRESS ______________________________ HOME PHONE _____-_____-_____

CITY ______________ STATE ________ ZIP CODE ________ CELL PHONE _____-_____-_____

EMPLOYER'S NAME ______________________ WHAT DO YOU DO THERE? ______________

EMPLOYER'S ADDRESS ______________________ YEARS WITH PRESENT EMPLOYER ________

WORK PHONE # _____-_____-______ EXT. # ________ OKAY TO CALL YOU AT WORK? YES NO

REFERRED TO OUR OFFICE BY ______________________

IN CASE OF EMERGENCY CONTACT ______________ PHONE # _____-_____-_____ RELATIONSHIP ________

PRIMARY CARE PHYSICIAN ______________ PHONE # _____-_____-_____ OK TO CONTACT THEM? ___Y ___N

ADDRESS ______________________ HOSPITAL/CLINIC AFFILIATION ______________

INSURANCE INFORMATION

I DO NOT HAVE HEALTH INSURANCE THAT COVERS CHIROPRACTIC CARE, AND CHOOSE TO PAY CASH. YES ☐ NO ☐

I AM INTERESTED IN A DISCOUNT CASH PLAN FOR WELLNESS CARE. YES ☐ NO ☐

IS YOUR CURRENT CONDITION THE RESULT OF AN ACCIDENT/INJURY? YES ___ NO ___ IF YES: AUTO ___ WORK ___ SLIP/FALL ___

WOMEN ONLY

WHAT WAS THE DATE OF YOUR LAST MENSTRUAL CYCLE? ______________

IF PREGNANT, HOW MANY WEEKS ALONG ARE YOU? ______________ WHAT IS YOUR DUE DATE? ______________

HOW MANY PREGNANCIES HAVE YOU HAD TO FULL TERM? ______________

WHAT IS THE NAME OF YOUR OB OR MIDWIFE? ______________________ PHONE # _____-_____-_____

APPOINTMENT

I WOULD LIKE A REMINDER VIA: _____ TEXT (CELL PHONE CARRIER____________) _____ E-MAIL _____ BOTH

BILLING

I WOULD LIKE BILLS SENT TO ME VIA: _____ E-MAIL _____ MAIL

PATIENT HEALTH QUESTIONNAIRE

PATIENT NAME: ____ DATE: ______________

1. WHAT ARE YOU BEING SEEN FOR TODAY?: ____
DESCRIBE YOUR SYMPTOMS AND WHEN THEY BEGAN: ____
____

2. HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?
   1. CONSTANTLY (76-100% OF THE DAY)
   2. FREQUENTLY (51-75% OF THE DAY)
   3. OCCASIONALLY (26-50% OF THE DAY)
   4. INTERMITTENLY (0-25% OF THE DAY)

3. WHAT DESCRIBES THE NATURE OF YOUR SYMPTOMS?
   1. SHARP 4. SHOOTING
   2. DULL ACHE 5. BURNING
   3. NUMB 6. TINGLING

4. HOW ARE YOUR SYMPTOMS CHANGING?
   1. GETTING BETTER
   2. NOT CHANGING
   3. GETTING WORSE

5. DESCRIBE YOUR SYMPTOMS AT THEIR:

	NONE										UNBEARABLE
A. WORST:	0	1	2	3	4	5	6	7	8	9	10
B. BEST:	0	1	2	3	4	5	6	7	8	9	10

6. HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES?

0	1	2	3	4	5	6	7	8	9	10
NO COMPLAINTS		MILD	MODERATE, INTERFERES WITH ACTIVITY			LIMITING, PREVENTS FULL ACTIVITY			INTENSE	SEVERE, NO ACTIVITY POSSIBLE

7. ACTIVITIES THAT MAKE SYMPTOMS WORSE: ____

8. ACTIVITIES THAT MAKE SYMPTOMS BETTER: ____

9. WHO HAVE YOU SEEN FOR YOUR SYMPTOMS? 1. NO ONE 2. OTHER CHIROPRACTOR 3. MEDICAL DOCTOR 4. PHYSICAL THERAPIST 5. OTHER
   A. WHEN AND WHAT TREATMENT?____
   B. HAVE YOU HAD ANY OF THE FOLLOWING?: 1. X-RAY DATE:_______ 2. MRI DATE:_______ 3. CT SCAN DATE:______

10. HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? 1. YES 2. NO
   A. IF YES, WHO DID YOU SEE? 1. THIS OFFICE 2. OTHER CHIROPRACTOR 3. MEDICAL DOCTOR 4. PHYSICAL THERAPIST 5.OTHER

11. WHAT DO YOU HOPE TO GET FROM YOUR VISIT/TREATMENT?
   1. REDUCE SYMPTOMS 2. RESUME/INC. ACTIVITY 3. EXPLANATION OF CONDITION/TREATMENT 4. LEARN TO TAKE CARE OF THIS ON MY OWN 5. HOW TO PREVENT REOCCURANCE 6. ____________________________

PATIENT SIGNATURE: ______________________________________ *DATE:* ______________________

PATIENT HEALTH QUESTIONNAIRE – PAGE 2

PATIENT NAME: ______________________________ DATE: ______________________

WHAT TYPE OF REGULAR EXERCISE DO YOU PERFORM? 1. NONE 2. LIGHT 3. MODERATE 4. STRENUOUS

WHAT IS YOUR HEIGHT AND WEIGHT? HEIGHT: _____ _____ (FEET INCHES) WEIGHT: _________ LBS.

DO YOU WEAR ORTHOTICS? Y ☐ N ☐ ARE YOU INTERESTED IN CUSTOM MADE ORTHOTICS? Y ☐ N ☐

FOR EACH CONDITION LISTED BELOW, PLACE A CHECK IN THE PAST COLUMN IF YOU HAVE HAD THE CONDITION IN THE PAST. IF YOU PRESENTLY HAVE A CONDITION LISTED BELOW, PLACE A CHECK IN THE PRESENT COLUMN.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	HEADACHES	☐	☐	HIGH BLOOD PRESSURE	☐	☐	DIABETES
☐	☐	NECK PAIN	☐	☐	HEART ATTACK	☐	☐	EXCESSIVE THIRST
☐	☐	UPPER BACK PAIN	☐	☐	CHEST PAINS	☐	☐	FREQUENT URINATION
☐	☐	MID BACK PAIN	☐	☐	STROKE			
☐	☐	LOW BACK PAIN	☐	☐	ANGINA	☐	☐	SMOKING/TOBACCO USE
						☐	☐	DRUG/ALCOHOL DEPENDENCE
☐	☐	SHOULDER PAIN	☐	☐	KIDNEY STONES			
☐	☐	ELBOW/UPPER ARM PX	☐	☐	KIDNEY DISORDERS	☐	☐	ALLERGIES
☐	☐	WRIST PAIN	☐	☐	BLADDER INFECTION	☐	☐	DEPRESSION
☐	☐	HAND PAIN	☐	☐	PAINFUL URINATION	☐	☐	SYSTEMIC LUPUS
			☐	☐	LOSS OF BLADDER CONTROL	☐	☐	EPILEPSY
☐	☐	HIP/UPPER LEG PX	☐	☐	PROSTATE PROBLEMS	☐	☐	DERMATITIS/ECZEMA/RASH
☐	☐	KNEE/LOWER LEG PX				☐	☐	HIV/AIDS
☐	☐	ANKLE/FOOT PAIN	☐	☐	ABNORMAL WEIGHT GAIN/LOSS			
			☐	☐	LOSS OF APPETITE			FEMALES ONLY
☐	☐	JAW PAIN	☐	☐	ABDOMINAL PAIN	☐	☐	BIRTH CONTROL PILLS
			☐	☐	ULCER	☐	☐	HORMONAL REPLACEMENT
☐	☐	JOINT SWELLING/STIFF	☐	☐	HEPATITIS	☐	☐	PREGNANCY
☐	☐	ARTHRITIS	☐	☐	LIVER/GALLBLADDER DISORDER			
☐	☐	RHEUMATOID ARTHRITIS						OTHER HEALTH PROBLEMS/ISSUES
☐	☐	GENERAL FATIGUE	☐	☐	CANCER	☐	☐	________
☐	☐	MUSCULAR INCOORDINATION	☐	☐	THYROID	☐	☐	________
☐	☐	VISUAL DISTURBANCE	☐	☐	ASTHMA	☐	☐	________
☐	☐	DIZZINESS	☐	☐	CHRONIC SINUSITIS	☐	☐	________

INDICATE IF AN IMMEDIATE FAMILY MEMBER (PARENT OR SIBLING) HAS HAD ANY OF THE FOLLOWING:
☐RUEMATOID ARTHRITIS ☐HEART PROBLEMS ☐DIABETES ☐CANCER ☐LUPUS ☐________

LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS, AND NUTRITIONAL/HERBAL SUPPLEMENTS YOU ARE TAKING:

____

____

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD AND ANY TIMES OF HOSPITALIZATION:

____

____

PATIENT SIGNATURE: ______________________________ DATE: ______________________

ADDITIONAL COMMENTS

____

Authorization to Release Information

________ I authorize BodyWise Chiropractic PLLC to release all information related to the care I receive to my HMO, insurance company, third party payor, or their designee, as may be necessary for the payment of my bill, determining benefits, or for utilization and quality review purposes.

Information about Possible Risks of Treatment

Appropriate tests will be done to identify any contraindications to chiropractic manipulative therapy prior to any treatment, and you will be notified if this is the case. If you have any questions, please ask Dr. Bennett.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disk injuries, or physiotherapy burns. These are extremely rare occurances. It is not uncommon to feel slight soreness following a treatment, but please do not hesitate to call with any concerns.

Consent for Treatment

________ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Assignment of Benefits

________ I assign to BodyWise Chiropractic PLLC all benefits payable to me for my care. I understand that generally this health care facility will be paid directly by the insurance company or other payor if so utilized. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

________ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Notice of 24 Hour Cancellation Policy

________ I understand if I fail to notify the office of a cancellation less than 24 hours prior to my scheduled appointment, I will be charged a $25.00 cancellation fee. If this occurs more than 3 times, I may be released from care due to failure to comply with my treatment plan and company policy.

________________________________ ________________ ________________

Signature of Patient or Responsible Party | Date | Relationship to Patient

____

Reason Patient is Unable to Sign