Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE OFFICE MANAGER

PATIENT INFORMATION

Today's Date: _____

Name: _____ **Date of Birth**___

Age: _____ ❑ **Male** ❑ **Female** **Social Security #:** _____

Address:_____ **City:**_____ **State:** _____**Zip:**_____

Home Phone: _____**Work Phone:** _____

Cell Phone:_____ **Email:**_____**(Health eNewsletters/Promotions)**

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other _____

Name of Spouse or Nearest Relative: _____Phone: _____

Your Occupation _____Your Employer: _____ Phone: _____

Referred to this Office by: ❑Friend/Family Member Name? _____

❑Yellow Pages ❑ Newspaper ❑Flyers ❑Clinic Location ❑Other_____

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance

❑Automobile Insurance ❑Worker's Compensation

Name of Insurance Co.: _____ Insured's Employer: _____

Policy Holder's Name: _____**Insured's Date of Birth**: _____

Policy ID#: _____ **Policy Group #:**_____

Policy Holder's Soc. Sec. #: _____

Are you covered by more than one insurance company? ❑Yes ❑No: Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which condition(s) have been experienced, by marking appropriate boxes.)

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date: _____

2._____ Date: _____

3._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No **Gunshot Wounds? ❑Yes ❑No**

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1._____ Date:_____

❑Job ❑Auto ❑Other 2._____ Date:_____

❑Job ❑Auto ❑Other 3._____Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms and problems Rate (1-10)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

Have you experienced any bowel or bladder problems? NO❑ YES❑

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT
WHEN AND HOW OCCURRED? _____
SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: _____
SYMPTOMS HAVE PERSISTED FOR # __ HOUR(S) __DAY(S) __WEEK(S) ___MONTH(S) ___ YEAR(S)
S**YMPTOMS/COMPLAINTS**: ❑COME & GO ❑ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN? _____

NAME AND LOCATION OF YOUR FAMILY DOCTOR AND DOCTORS SEEN FOR CURRENT CONDITION:
_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS: ❑NO ❑YES:
IF YES WHAT KIND? _____
ARE YOU TAKING ANY MEDICATIONS: ❑NO ❑YES:
IF YES, WHAT KIND? _____
ARE YOU PREGNANT: ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY <u>ADDITIONAL SYMPTOMS</u> YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Do you give your consent for our office to use your <u>first name and last initial</u> in any future publications (i.e. Health eNewsletters, testimonials, and for purposes of welcoming new patients and acknowledging patients of the month)? ❑Yes ❑No Initials____

I, the undersigned certify that I or my dependant have insurance coverage with _____ and will assign directly to Body Solutions Chiropractic and Rehabilitation Center, Ltd. Insurance benefits, if any, otherwise payable to Body Solutions Chiropractic and Rehabilitation Center, Ltd., for services rendered. I, the patient, understand that I am financially responsible for these charges whether or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Do you qualify for financial hardship or need to make arrangements for a payment plan? ❑Yes ❑No

Patient's Signature: _____ Date: _____