BodyWorks Chiropractic- New Patient Packet

Name: _____ **Date:** _____

Phone Number: _____ **Email:** _____

Address: _____

City/State/Zip: _____

Age: _____ **Date of Birth:** _____ **Occupation:** _____

How did you hear about us? _____

Emergency Contact Name: _____

Phone Number: _____

Medical History

Please List Current Medications/Vitamins:

Have you ever been diagnosed or suffer from the following?

___Broken or Fractured Bones ___Arthritis ___ eating disorder

___Circulatory Problems ___Epilepsy ___Alcoholism

___Pacemaker/Defibrillator ___Stroke ___Drug Addiction

___HIV Positive or ___Cancer ___High/Low Blood Pressure

___Diabetes Do you bruise easily? YES or NO

___Other: _____

Have you ever had any major illnesses, injuries, or surgeries? With Dates:

_____

_____

Name & Phone Number for Primary Care Provider: _____

_____

Date of last physical: _____

Please list allergies: _____

Social History

How many alcoholic beverages do you drink/week? _____

Do you use tobacco products? _____ **Packs/day:** _____

How much caffeine do you have/day? _____ **How much water do you drink/day?** _____

What kind of exercise do you do and how frequently? _____

What are your hobbies? _____

What percentage of the day do you:

_____Sit _____Stand _____Lift _____Bend _____Computer work Other _____

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Family History

Father: ____ Living ____ Deceased. If deceased, age & cause: _____

Mother: ____Living ____Deceased. If deceased, age & cause: _____

Do you have any family members that suffer from the same condition you do? If so list relation, age, condition: _____

_____

Family Diseases: (Mark Father, Mother, Sister, Brother)

____Tuberculosis ____Cancer ____Mental Illness ____Other: _____

Additional Family History: _____

Summary of Condition

1. **What is your major symptom?** _____
2. **Circle your level of pain: (minimal) 1 2 3 4 5 6 7 8 9 10 (hospital)**
3. **What does this prevent you from doing?** _____
4. **Does it travel to another area?** (i.e.-down the legs)
   _____
5. **If this a recurrence, when was the first time you noticed this problem?** _____
   a. **How did it originally occur?** _____
   b. **Has it become:** __Worse __Better __Same
6. **Frequency of condition?** __Constant __Intermittent __Daily __Nightly Other: _____
7. **How long does it last?** __All Day __Few Hours __Few Minutes Other: _____
8. **Describe the pain** __Achy __Stiff __Sore __Dull __Sharp __Numb __Tingling __Burning __Stabbing Other:_____
9. **What helps relieve the pain?** _____
10. **What makes it worse?** _____
11. **List any other conditions or symptoms that may or may not be related to your major symptoms:** _____
12. **WOMAN ONLY:** Are you pregnant or could be pregnant? __Yes __No
13. **Additional Information:** _____
    _____

Patient's Printed Name: _____

Signature: _____ **Date:** _____

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Insurance/HIPPA

Please mark all that apply to this case:

____Major Medical ____Workers Compensation ____Medicare ____Auto Accident

Name of Primary Insurance: _____

Name of Secondary Insurance (If applies): _____

Authorization and Release: I authorize payment of Insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians, healthcare providers, payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of Insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due of payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. You will need to sign a consent form to release or inactive your records to another healthcare clinic. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. A complete HIPPA NOTICE is available at your request.

Patient's Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

BodyWorks Chiropractic will not treat any condition outside their scope of practice. Referral to another healthcare professional may be indicated. Co-Management may be used to manage your condition. Chiropractors diagnose and treat muscular and skeletal conditions. If diagnostic imaging is indicated, referrals may be made.

Patient's Signature: _____ **Date:** _____

Guardian's Signature Authorizing Care: _____ **Date:** _____

BodyWorks Chiropractic uses texts and emails for reminder appointments and occasional announcements.

Sign: Agree: _____ **OR opt out:** _____

List the people and phone numbers of who we can send records to if needed. If no one is listed, records will not be sent without your written permission.

1. _____

2. _____