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_____

STREET ADDRESS _____ HOME PHONE _____-_____-_____

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

PROFESSION _____ EMAIL ADDRESS _____

REFERRED TO OUR OFFICE BY _____

IN CASE OF EMERGENCY CONTACT _____ PHONE # ____-_____-_____ RELATIONSHIP _____

PRIMARY CARE PHYSICIAN _____ 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 # _____-_____-_____

Tell us about your Foot Health

Do you have foot pain? Y N

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

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

HOW MANY DAYS PER WEEK DO YOU WEAR THESE TYPES OF SHOES:

ATHLETIC_____DRESS _____HIGH HEELS _____ FLATS_____ FLIPFLOPS_____INDUSTRIAL_____

PATIENT HEALTH QUESTIONNAIRE PG 2

PATIENT NAME: _____ DATE:_____

HOW DO YOUR SYMPTOMS AFFECT YOUR ABILITY TO PERFORM DAILY ACTIVITIES? (PAIN LEVEL COMMENT BELOW)

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

WHAT ARE YOU BEING SEEN FOR TODAY?

A_____ B_____ C_____

How often do you experience symptoms?

Symptom	A	B	C	Pain Level Comment
Consistently (76-100% of the day)				
Frequently (51-75% of the day)				
Occasionally (26-50% of the day)				
Intermittently (0-25%of the day)				

What describes the nature of your symptoms? **How are your symptoms changing?**

Symptom	A	B	C	Pain Level Comment	Symptom	A	B	C	Pain Level Comment
Sharp					Getting Better				
Dull					Not Changing				
Numb					Getting Worse				
Shooting									
Burning									
Tingling									

WHAT IS YOUR HEIGHT AND WEIGHT? **HEIGHT: _____ _____** **WEIGHT: _____ LBS.**

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

ACTIVITIES THAT MAKE SYMPTOMS WORSE: _____
ACTIVITIES THAT MAKE SYMPTOMS BETTER: _____

WHO HAVE YOU SEEN FOR YOUR SYMPTOMS? 1. NO ONE 3. MEDICAL DOCTOR 5. OTHER
2. OTHER CHIROPRACTOR 4. PHYSICAL THERAPIST

A. WHEN AND WHAT TREATMENT?_____

B. HAVE YOU HAD ANY OF THE FOLLOWING?: 1. X-RAY DATE:_____ 3. CT SCAN DATE:_____
2. MRI DATE:_____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? 1. YES 2. NO

A. IF YES, WHO DID YOU SEE? 1. THIS OFFICE 3. MEDICAL DOCTOR 5.OTHER
2. OTHER CHIROPRACTOR 4. PHYSICAL THERAPIST

WHAT ARE YOUR GOALS REGARDING TODAY'S VISIT/TREATMENT? _____

_____

PATIENT SIGNATURE: _____ ***DATE:*** _____

PATIENT HEALTH QUESTIONNAIRE – PG 3
PATIENT NAME: _____ DATE: _____

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	Condition	Past	Present	Condition	Past	Present	Condition
		Headache			↑Blood Press			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Jaw Pain			Chest pain			Frequent Urination
		Upper Back			Stroke			
		Mid Back			Angina			Smoking/Tobacco Use
		Lower Back						Drug/Alcohol Dependence
		Shoulder			Kidney Disorders			Allergies
		Elbow/Upper Arm			Bladder Infection			Depression
		Wrist Pain			Painful Urination			Systemic Lupus
		Hand Pain			Loss of Bladder Ctrl			Epilepsy
					Prostate Problems			Dermatitis/Eczema Rash
		Hip/Pelvis/Upper Leg						HIV/AIDS
		Knee/Lower Leg			Abnormal Weight Chges			**FEMALES ONLY**
		Ankle/Foot			Ulcer			Birth Control Pills
					Hepatitis			Hormonal Replacement
		Joint Swelling/Stiff			Liver/Gall Bladder			Pregnancy
		Arthritis						**OTHER HEALTH ISSUES**
		Rheumatoid Arthritis			Cancer			
		General Fatigue			Thyroid			
		Muscular Incoordination			Asthma			
		Visual disturbance			Chronic Sinusitis			
		Dizziness						

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: _____

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.

CONSENT FOR TREATMENT FOR MEDICAL ACUPUNCTURE

_____I HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF ACUPUNCTURE TREATMENTS. ACUPUNCTURE IS THE INSERTION OF A THIN NEEDLE INTO THE SURFACE OF THE BODY. ACUPUNCTURE ATTEMPTS TO NORMALIZE PHYSIOLOGICAL FUNCTIONS, TO MODIFY THE PERCEPTION OF PAIN AND TO TREAT CERTAIN DISEASES OF DYSFUNCTION OF THE BODY. I HAVE BEEN INFORMED THAT ACUPUNCTURE IS A SAFE METHOD OF TREATMENT, BUT OCCASIONALLY THERE MAY BE SOME BRUISING OR TINGLING NEAR THE NEEDLING SITES THAT LAST A FEW DAYS. THERE HAVE BEEN VERY RARE INSTANCES REPORTED OF FAINTING, INFECTION AND SCARRING. THERE HAVE BEEN EXTREMELY RARE INSTANCES OF SPONTANEOUS MISCARRIAGE AND PNEUMOTHORAX. INFECTION IS ANOTHER POSSIBLE RISK, ALTHOUGH THE CLINIC USES STERILE DISPOSABLE NEEDLES AND MAINTAINS A CLEAN AND SAFE ENVIRONMENT.

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. A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED AS VALID AS THE ORIGINAL. 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 I HAVE AN ACTIVE CASH PLAN, I UNDERSTAND A SESSION WILL BE DEDUCTED IN THE EVENT OF A NO SHOW.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE** **RELATIONSHIP TO PATIENT**

_____

REASON PATIENT IS UNABLE TO SIGN