

BodyMind Chiropractic Center

Confidential Patient Record

Patient Intake Form

Name: _____ Date: _____

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

Phone: Home: _____ Work: _____ Cell: _____

Preferred # to contact between 9AM and 5PM: Home Work Cell Email: _____

Social Security #: _____ Birth date: ____/____/____ Sex: M F

Employer: _____ Type of Work: _____

Check one: Married Partner Single Separated/Divorced Name of Spouse/Partner: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Referred to this office by: _____

Have you ever been to a chiropractor before? YES NO Name of Chiropractor: _____

If YES: what did you like about it? _____

what did you not like about it? _____

If NO: do you have any concerns about being here? _____

Current Health Condition

Purpose of this visit: _____

When did this condition begin? _____ Have you had it before: YES NO When: _____

Other doctors seen for this condition: YES NO Dr.'s Name: _____

Treatment: _____

Results: _____

What activities aggravate the condition? _____

Is there anything that helps? _____

Is this condition getting worse? YES NO Comes and goes Constant

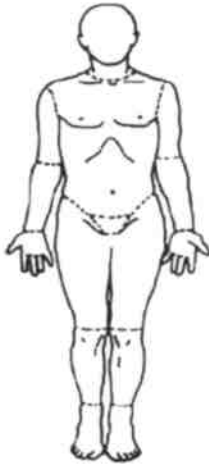
Is this condition worse at a certain time of day? _____

Is this condition interfering with Work Sleep Daily routine Other _____

Is this condition Job related Auto accident Home injury Fall Other _____

Did this condition come on slowly over time? YES NO Other _____

Please indicate on the diagram the area of your discomfort



Sharp and Stabbing = +++++
 Dull and Achy = VVVV
 Pins and Needles = XXXX
 Numbness = ////



Rate your symptoms at their:
 None Unbearable
 worst: 0 1 2 3 4 5 6 7 8 9 10
 best: 0 1 2 3 4 5 6 7 8 9 10

Past Medical History

The following health history questions may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully as these problems can affect your overall course of care.

Surgeries: _____

Significant Trauma: _____

Allergies (drugs, chemicals, foods): _____

Occupational Stresses (chemical, physical, psychological, etc.): _____

Significant Illnesses (check any of the following you have had):

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> TMJ | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Other (describe): _____ | | |

Medications

Please indicate the medications you are currently taking.

Name	Dosage	Purpose

BodyMind Chiropractic Center

Medical Symptoms Questionnaire

Patient Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days:

Point Scale
 0 – Never or almost never have the symptoms
 1 – Occasionally have it, effect is not severe
 2 – Occasionally have it, effect is severe

3 – Frequently have it, effect is not severe
 4 – Frequently have it, effect is severe

HEAD
 _____ Headaches
 _____ Faintness
 _____ Dizziness
 _____ Insomnia
 _____ TOTAL

DIGESTIVE TRACT
 _____ Diarrhea
 _____ Constipation
 _____ Bloating feeling
 _____ Belching, passing gas
 _____ Heartburn
 _____ Intestinal/stomach pain
 _____ TOTAL

EYES
 _____ Watery or itchy eyes
 _____ Swollen, reddened, or sticky eyelids
 _____ Bags or dark circles under eyes
 _____ Blurred or tunnel vision
 _____ TOTAL

JOINTS/ MUSCLE
 _____ Pain or aches in joints
 _____ Arthritis
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Feeling of weakness or tiredness
 _____ TOTAL

EARS
 _____ Itchy ears
 _____ Earaches, ear infections
 _____ Drainage from ear
 _____ Ringing in ears, hearing loss
 _____ TOTAL

WEIGHT
 _____ Binge eating/drinking
 _____ Craving certain foods
 _____ Excessive weight
 _____ Compulsive eating
 _____ Water retention
 _____ Underweight
 _____ TOTAL

NOSE
 _____ Stuffy nose
 _____ Sinus problems
 _____ Hay fever
 _____ Sneezing attacks
 _____ Excessive mucus formation
 _____ TOTAL

ENERGY/ ACTIVITY
 _____ Fatigue, sluggishness
 _____ Apathy, lethargy
 _____ Hyperactivity
 _____ Restlessness
 _____ TOTAL

MOUTH/ THROAT
 _____ Chronic coughing
 _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen or discolored tongue gums lips
 _____ Canker sores
 _____ TOTAL

MIND
 _____ Poor memory
 _____ Confusion, poor comprehension
 _____ Poor concentration
 _____ Poor physical coordination
 _____ Difficulty in making decisions
 _____ Stuttering or stammering
 _____ Slurred speech
 _____ Learning disabilities
 _____ TOTAL

SKIN
 _____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Flushing, hot flashes
 _____ Excessive sweating
 _____ TOTAL

HEART
 _____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain
 _____ TOTAL

EMOTIONS
 _____ Mood swings
 _____ Anxiety, fear, nervousness, stress
 _____ Anger, irritability, aggressiveness
 _____ Depression
 _____ TOTAL

LUNGS
 _____ Chest congestion
 _____ Asthma, bronchitis
 _____ Shortness of breath
 _____ Difficulty breathing
 _____ TOTAL

OTHER
 _____ Frequent illness
 _____ Frequent or urgent urination
 _____ Genital itch or discharge
 _____ TOTAL
 _____ **GRAND TOTAL**

Lifestyle

Describe your exercise activities and frequency:

Describe your typical diet

Vitamins

		Quantity
Coffee intake	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Alcohol Consumption	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Cigarettes	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Recreational drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

Family Medical History

Please indicate which family members have had any of the following diseases (please indicate M-maternal or P-paternal):

- Diabetes _____
- Cancer (indicate type) _____
- High Blood Pressure _____
- Heart Disease _____
- Stroke _____
- Autoimmune _____
- Asthma _____
- Allergies _____
- Alcoholism _____
- Parkinson's/Alzheimer's _____
- Depression/Anxiety _____
- Other _____

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. The doctor will not be held responsible for any pre-existing diagnosed conditions, nor for any medical diagnosis.

Patient's Signature _____ Legal Guardian _____ Date _____

BodyMind Chiropractic Center
Assignment of Benefits and Patient Acknowledgement

Assignment of Benefits

I hereby assign my insurance benefits to BodyMind Chiropractic Center. I authorize and direct my insurance carrier, including Medicare, private insurance, and any other health/medical plan, to issue payment directly to BodyMind Chiropractic Center for services rendered.

I understand that the benefits quoted by my insurance company are not a guarantee of payment and that I am financially responsible to BodyMind Chiropractic Center for any and all charges not covered by my insurance carrier. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed, any outstanding balance is due and payable immediately. Charges not covered by insurance are due and payable at the time of service.

Authorization for the Release of Medical Information

I authorize the release of any medical or other pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity, for continued medical care.

Missed Appointments

Appointments missed without prior notification will be assessed a \$25.00 fee. Missed appointment charges are not covered by insurance.

Notice of Privacy Practices (HIPAA)

By signing this document, I also acknowledge that I have received a copy of the Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Patient Acknowledgement

A photocopy of this document shall be considered as effective and valid as the original. I understand that I may cancel this authorization through written notice to BodyMind Chiropractic Center.

Patient Name

Signature of Patient or Guardian

Date