

Body Traxx Chiropractic
Confidential Patient Information



Name: _____ SS# _____ - _____ - _____

Age: ____ Birth Date: _____ Cell: (____) ____ - _____ E-mail: _____

Address _____ City _____ State _____ Zip _____

Male or Female Marital: M S W D How many children? ____ Occupation _____

Closest Family Member (parent if minor) _____ Cell: (____) ____ - _____

How did you hear about us? Google/Web Walk-In Friend: _____

Purpose of appointment (current problem) _____

Other doctors seen for this condition _____

Is the condition due to injury or sickness arising out of an auto accident? yes no

Do you suffer from: (Please check all that apply to you.)

- | | | | |
|------------------------------------|--|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder/Arm Pain | <input type="checkbox"/> Hip/Leg Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Numbness | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Male/Female Troubles |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Heart Trouble |

Have you been treated for any health condition by a physician in the last year? yes no

If yes, Describe: _____

What medications are you taking? _____

What vitamins are you taking? _____

Females Only: Are you taking birth control pills? no yes Pregnant? no yes

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Release of Information: By signing this form, you are granting consent to Body Traxx Chiropractic · Weight-Loss to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Signature (or Guardian Signature Authorizing Care)

Date

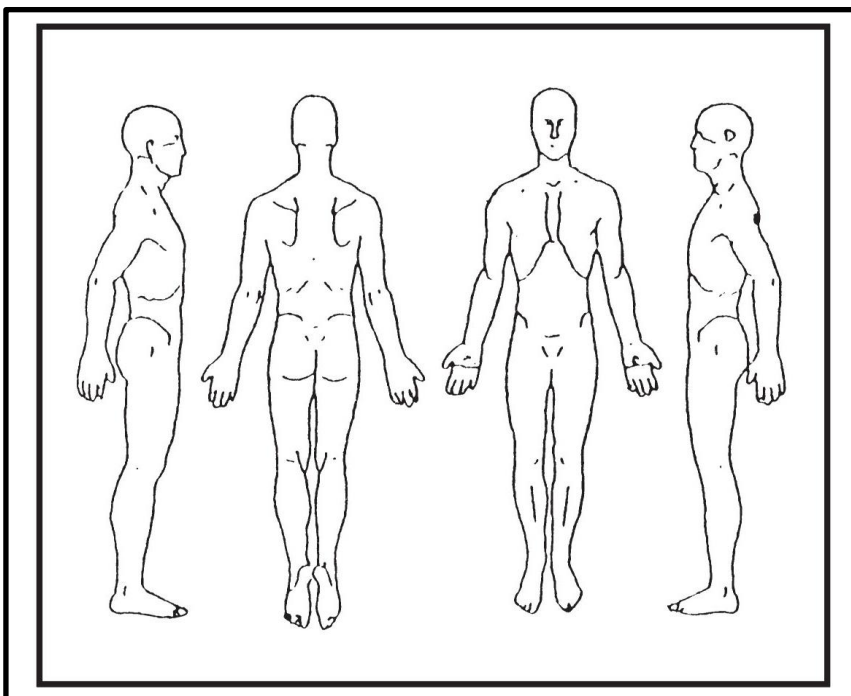
Please fill out back side

Patient Name _____ Date _____

1. What is your major symptom? _____
2. When was the first time you noticed this problem? _____
How did it occur? _____
Has it become worse recently? _____ If yes, When and How? _____
3. How frequent is the condition? : Constant Frequent Occasional Intermittent
4. Have you ever had the same or similar condition? no yes If yes, when and describe: _____
5. If pain is involved is it: sharp dull throbbing stabbing aching burning tingling shooting?
(Other) _____
6. Is there anything you can do which seems to provide relief? _____
7. What makes the problem worse? _____
8. List accidents, illness, surgeries, or broken bones: _____

IMPORTANT!

9. Please Circle Your Symptom Areas



10. Rate the Severity of Your Condition

