

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
(First) (MI) (Last)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ O Male O Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
O Single O Married O Widowed O Divorced Occupation: \_\_\_\_\_  
Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Which do you prefer?  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ O  
E-mail: \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ O  
Work Phone: (\_\_\_\_) \_\_\_\_\_ O

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Whom can we thank for referring you to the clinic? \_\_\_\_\_

**INSURANCE**

Name of the Insured: \_\_\_\_\_  
SSN of the Insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary Insurance:  
Insurance Company: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_

Secondary Insurance:  
Insurance Company: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_

Is your visit for:  Auto Accident  Worker's Comp  Other  
Are you covered through Medicare?  Yes  No

**ACKNOWLEDGEMENTS**

\_\_\_\_\_ I hereby authorize Body of Health Chiropractic & Wellness Center to provide chiropractic services for me.

\_\_\_\_\_ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Body of Health Chiropractic & Wellness Center.

\_\_\_\_\_ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Body of Health Chiropractic & Wellness Center, 985 NW 23<sup>rd</sup> St. Corvallis, OR 97330.

\_\_\_\_\_ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

\_\_\_\_\_  
PATIENT SIGNATURE DATE

\_\_\_\_\_  
GUARANTOR'S SIGNATURE RELATIONSHIP TO PATIENT DATE



## PERSONAL HEALTH HISTORY

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

Please Circle current problems and put an "X" next to conditions you have had in the past

**General**

- Allergies \_\_\_\_\_
- Persistent Depression
- Dizziness
- Fainting
- Persistent Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Unexpected Weight loss / gain

**Muscle / Joint**

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid-back pain
- Joint pain

**Skin**

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Persistent Itching
- Rash

**Varicose veins**

**Eye, Ear, Nose & Throat**

- Colds per year? \_\_\_\_\_
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears

- Sinus infection
  - Sore throat
  - Tonsillitis
  - Vision problems
- Gastrointestinal**
- Abdominal pain
  - Bloody or tarry stool
  - Colitis / Crohn's
  - Colon trouble
  - Constipation
  - Diarrhea
  - Difficult digestion
  - Diverticulosis
  - Bloating abdomen
  - Excessive hunger
  - Gallbladder trouble
  - Hernia
  - Hemorrhoids
  - Intestinal worms
  - Jaundice
  - Liver trouble
  - Nausea
  - Painful defecation
  - Pain over stomach
  - Poor appetite
  - Vomiting
  - Vomiting of blood

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**Genitourinary**

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Pus in urine
- Stress incontinence
- Urinate overnight more than twice
- Urinate more than 8x in 24hrs
- Decreased flow/force

- Painful urination
  - Urgency to urinate
- Cardiovascular**
- High blood pressure
  - Low blood pressure
  - Hardening of the arteries
  - Irregular pulse
  - Pain over heart
  - Palpitation
  - Poor circulation
  - Rapid heart beat
  - Slow heart beat
  - Swelling of ankles

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**Respiratory**

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

**Women only**

- Congested breasts
  - Hot flashes
  - Lumps in breast
  - Menopause
  - Vaginal discharge
- Menstrual flow
- Reg.  Irreg.  Pain / cramps
  - Days of flow: \_\_\_\_\_ Length of cycle: \_\_\_\_\_
  - Date - 1<sup>st</sup> day last period: \_\_\_\_\_

- Are you pregnant?  yes,  no
- If yes, how many months? \_\_\_\_\_
- How many children do you have? \_\_\_\_\_
- Birth control method: \_\_\_\_\_
- Date of last PAP test: \_\_\_\_\_
- normal,  abnormal
- Date of last mammogram: \_\_\_\_\_
- normal,  abnormal

**Check any of the conditions you have or have had:**

- Alcoholism

- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

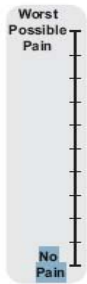


Describe your reason(s) for seeking care: \_\_\_\_\_

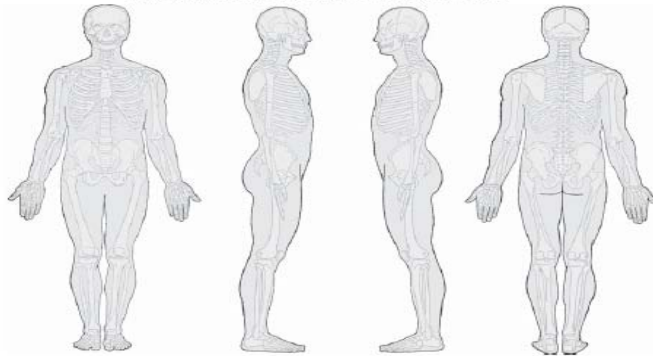
Please list any medication you are currently taking and why: \_\_\_\_\_

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long ago? _____	
Are you currently under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what reason?	
Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No for serious injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Indicate the drugs do you now take? <input type="checkbox"/> Birth control pills <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Pain Killers <input type="checkbox"/> Other (specify)	
Do you wear: <input type="checkbox"/> heel lifts? <input type="checkbox"/> sole lifts? <input type="checkbox"/> inner soles? <input type="checkbox"/> area supports? <input type="checkbox"/> negative heels? <input type="checkbox"/> platform shoes?	
What is the age of your mattress? _____ Is it <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable?	
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)	

Please place a mark at the level of your pain on the scale below:



Please mark you area(s) of pain on the figure below



Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
- been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
- used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
- been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you:	Yes	No
- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years. \_\_\_\_\_

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When did you last have:
- spinal x-ray?
_____
- spinal examination?
_____
- physical examination?
_____

**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS



**BODY of HEALTH**

Chiropractic and Wellness Center

## **Privacy Policy**

**THIS NOTICE DESCRIBES HOW YOUR CHIROPRACTIC/MEDICAL INFORMATION MAY BE USED/DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient of Body of Health Chiropractic and Wellness Center we may use or disclose personal and health information about you in the following ways:

- Your protected health information, including your medical records, may be disclosed to another health care provider or hospital if it is deemed necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance company, an HMO, a PPO, or your employer if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and e-mail may be used to contact you regarding appointment reminders, information about your care, alternatives to your present care, or other health-related information that may be of interest to you.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operation purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related health information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternate locations.

We are permitted and may be required to use or disclose your protected health information without your authorization in the following circumstances:

- If we provide health care services to you in an emergency situation.
- If we are required by law to provide care to you and we are unable to obtain your consent.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or other appropriate agency.

You have the right to receive an account of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be

made upon your written authorization. If you provide authorization for the release of your information, you have the right to revoke that authorization at a later date.

Because we value your privacy and are required by law we will maintain the privacy of your patient file and health protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to amend the terms of this privacy notice. You will be notified in writing immediately following any changes to our privacy practices. Any changes to our privacy practices will apply to all of your health information in our files.

If you have any questions or concerns regarding our privacy practices, this privacy practices notice or anything else regarding the use/disclosure of your health information please direct your questions or concerns to:

**Privacy Officer**  
985 NW 23<sup>rd</sup> St  
Corvallis, OR 97330

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**If you are a minor (under 18 years of age)**

\_\_\_\_\_  
Name of Parent or Legal Guardian (Printed)

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date