

PATIENT INFORMATION

Name: _____ Preferred Name: _____
(First) (MI) (Last)

Address: _____ Home Phone: (____) _____ Which do you prefer?
 City: _____ State: _____ Zip: _____ Mobile Phone: (____) _____
 E-Mail: _____ Work Phone: (____) _____

Date of Birth: ____/____/____
 Social Security #: ____-____-____

Please mark if one of these applies to you:
 Student Active Duty Military

Male Female

Single Married Widowed Divorced
 Spouse: _____

Occupation: _____
 Employer: _____

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

FINANCIAL/CASE INFORMATION

Auto/Personal Injury Worker's Comp Other

I have insurance which covers Chiropractic (please provide your current insurance card to reception)

I will be paying cash/check/credit card at the time of service

I am interested in 0% financing through CareCredit™

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 insurance benefits, including chiropractic, major medical, private insurance and all other health plan benefits to which I am entitled for care from Body of Health, to Body of Health Chiropractic & Wellness Center, 985 NW 23rd 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



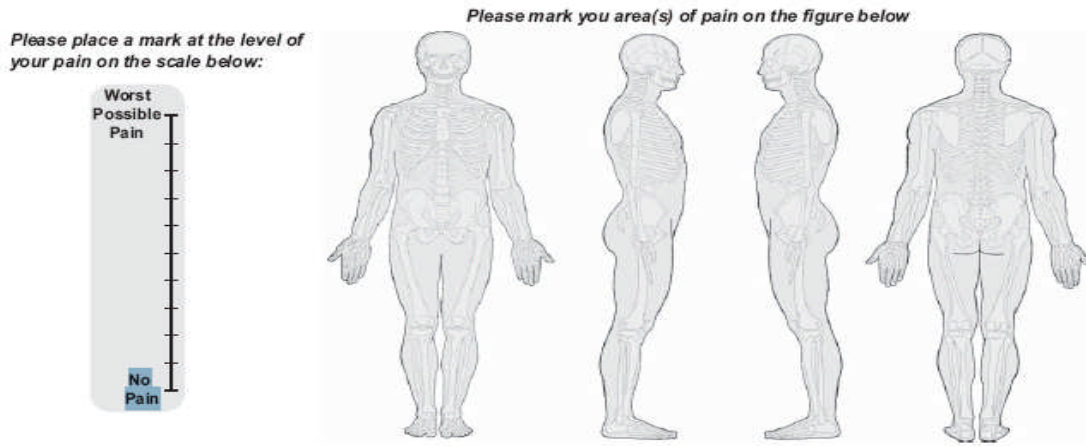
PERSONAL HEALTH HISTORY

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. To be responsible for your case, we need your *complete* health history.

Please mark any of the following you are experiencing:

- Neck Pain (723.1)
 Upper/Mid back pain (724.1)
 Low Back Pain (724.2)
 Sciatica/Leg symptoms (724.3)
 Headache (784.0)
 Pain in the limbs (729.5)
 Jaw Pain (524.6)
 Other _____



How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
What seemed to be the initial cause?	
Does it bother your (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
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?

Please list any SURGERIES or OVERNIGHT HOSPITALIZATIONS with dates:

Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
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FAMILY HEALTH HISTORY:

RELATIONSHIP	LIST ANY PAST OR PRESENT CANCER, DIABETES, HEART, LUNG, CARDIOVASCULAR or OTHER CONDITIONS
Mother	
Father	
Siblings	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Other	

<p>Please list any MEDICATIONS, VITAMINS or SUPPLEMENTS including dosage and how long you have been taking each if possible:</p>	<p>Please list any ALLERGIES you have:</p>
<p>Please list any TRAUMAs or INJURIES you have suffered (sports injuries, fractures, motor vehicle injuries, etc):</p>	<p>Please list any MEDICAL CONDITIONS you currently have or serious conditions you have had in the past:</p>
<p>Rate the following on a scale of 0 (least) – 10 (most)</p> <p>Healthiness of your diet 0 1 2 3 4 5 6 7 8 9 10</p> <p>Your physical fitness 0 1 2 3 4 5 6 7 8 9 10</p> <p>Physical Stress 0 1 2 3 4 5 6 7 8 9 10</p> <p>Emotional Stress 0 1 2 3 4 5 6 7 8 9 10</p> <p>Quality of your sleep 0 1 2 3 4 5 6 7 8 9 10</p>	

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"/>
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"/>

<p>Current Smokers:</p> <p>What is your level of interest in quitting? 0 1 2 3 4 5 6 7 8 9 10</p> <p>How long have you been smoking?</p>
<p>Past Smokers:</p> <p>How long ago did you quit?</p> <p>How long did you smoke prior to quitting?</p>

<p align="center">For Women Only</p> <p>Date of the start of your last MENSTRUAL PERIOD ____/____/____</p> <p>Are you currently or could you be PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes how many weeks? ____</p> <p>Have you experienced MENOPAUSE? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
