Body in Motion Chiropractic Clinic, PC

Patient Personal Data

Date_____/_____/_____

Legal Last Name:_____MI:____First Name_____Date of Birth___/___/___
Address_____City_____State_____Zip_____
Home Ph_____Work Ph_____Cell_____Cell Carrier_____
E-Mail hm:_____E-Mail wk:_____
Social Security #_____Age_____ ☐ Male ☐ Female
Occupation_____Employer_____
Marital Status ☐ Married-Spouse's name _____ ☐ Single ☐ Divorced ☐ Widowed
Contact in case of an emergency_____Phone #_____
Please check your contact Preference___Hm___Wk___Cell___Email___Other_____
How did you hear about our office:_____
Language: ___English___Spanish___Indian___Japanese___Chinese___Korean___French
Race:___White___American Indian/Alaska Native___Asian___Native Hawaiian/Other Pacific Islander
___Black/African American___Hispanic/Latino___Decline to answer___Other_____
Ethnicity:___Hispanic/Latino___Not Hispanic/Latino___Decline to Answer
Would you like us to send your records to any medical provider/doctors? (If so, please list them)?_____
_____

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Payment for services ☐ Cash/Check ☐ Credit card ☐ Health Insurance ☐ Auto ☐ Worker's Comp

Name of Patients Insurance Company: we will make copy of card
Are you the policy holder?__Y__N
if no, who is the policy holder: Spouse Parent Employer Other
Policy holders Name:_____
Policy holders DOB:___/___/___
Policy holders Employer:_____
Policy #_____
Group #_____
Address_____
Phone #_____

If auto accident:
If violation was issued, to whom was it issued?
_____
Were you wearing your seat belt?
_____
Insurance Company Name_____
Agent or Team Name/#_____
Claim #_____
Phone #_____

Insurance Information

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Therefore, although Body in Motion Chiropractic Clinic, PC will prepare the insurance forms, I am responsible for payment of services rendered. Direct payments made from the insurance company to Body in Motion Chiropractic Clinic, PC will be credited to my account upon receipt and any balances due will be my responsibility. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

Patient Signature_____**Parent/Guardian** _____

Dr Bartholet understands that occasionally, patients may need to reschedule their appointments. Because of the personalized attention each patient receives at Body in Motion Chiropractic, it is preferred that patients cancel at least 24 hours in advance. Patients who miss their appointment without notifiying the doctor should expect a $25.00 **"no-show" fee**. Initial:_____

Consent of Professional Services

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examina- tion, or any clinic services that he/she deems necessary in my case. I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____Parent/Guardian _____

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Patient Health Questionnaire

Body in Motion
Chiropractic Clinic, PC

Name_____Date_____

1. Please describe your major complaint_____
_____
_____

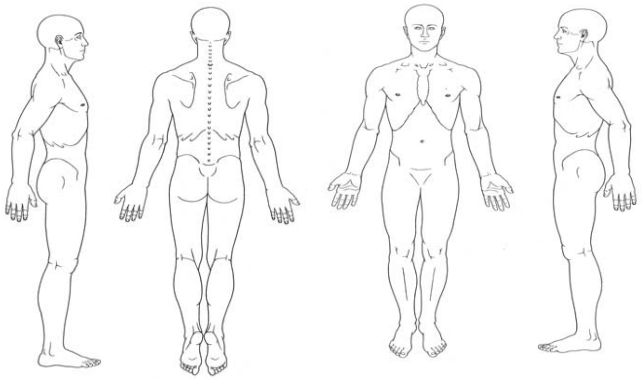
a. Description

- ☐ Sharp Pain
- ☐ Dull Pain
- ☐ Ache
- ☐ Stiffness
- ☐ Weak
- ☐ Burning
- ☐ Tingling
- ☐ Numb
- ☐ Shooting Pain

b. Frequency

- ☐ Constant (75-100%)
- ☐ Frequent (50-75%)
- ☐ Occasional (25-50%)
- ☐ Intermittent (25% or less)

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



c. Please circle the number that best describes your pain 0 1 2 3 4 5 6 7 8 9 10

NO PAIN MEDUIM SEVERE

d. Your symptoms are:

☐ Increasing ☐ Not changing ☐ Decreasing

e. Your symptom worse in the

☐ Morning ☐ Afternoon ☐ Evening ☐ While you sleep ☐ Same all day

2. When did your problem begin?_____Describe how your problem began_____
_____
_____

3. What makes your problem better? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing
☐ Sitting ☐ Exercise ☐ Medication ☐ Other (please explain)_____

4. What makes your problem worse? ☐ Nothing ☐ Lying down ☐ Walking ☐ Standing ☐ Coughing
☐ Sitting ☐ Exercise ☐ Other (please explain)_____

5. How would you rate your general stress level? ☐ Litte or no stress ☐ Moderate stress ☐ High stress

6. General physical activity:
☐ No regular exercise ☐ Light exerise ☐ Moderate exercise ☐ Strenous exercise program

7. Are your complaints affecting your everyday tasks?
☐ No affect ☐ Need assistance, explain:_____

8. Physical activity at work: ☐ Sitting more than 50% of workday ☐ Light manual labor
☐ Heavy manual labor ☐ Repeated motion

9. Has your work status changed because of your complaint? ☐ yes ☐ no
If Yes, how: _____

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10. Have you been treated for this episode/current complaint? ☐ yes ☐ no

If yes, by whom? _____

11. In the past have you been treated for the same or similar problem? ☐ yes ☐ no

If yes, by whom and what treatment did you receive?_____

_____

If yes, was the treatment effective? Why do you think it was or wasn't effective?_____

_____

If you have ever had a listed condition in the past please check it in the past column. If you are currently troubled by a condition listed please check the present column. The information you provide assists your doctor to more thoroughly understand your state of health.

Past	Present	
☐	☐	Neck pain (723.1)
☐	☐	Shoulder pain (719.41)
☐	☐	Arm pain (719.42)
☐	☐	Hand pain (719.44)
☐	☐	Wrist pain (719.43)
☐	☐	Upper back pain (724.1)
☐	☐	Low back pain (724.2)
☐	☐	Upper leg/hip pain (719.45)
☐	☐	Lower leg/knee pain (729.5)
☐	☐	Ankle or foot pain (719.47)
☐	☐	Headache (784)
☐	☐	Dizziness (780.4)
☐	☐	Tinnitus/ear noises (388.30)
☐	☐	Chest pains (786.50)

Past	Present	
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy/Seizures (349.5)
☐	☐	Fibromyalgia (729.1)
☐	☐	Abdominal pains (789.0)
☐	☐	High blood pressure (401.9)
☐	☐	Constipation/irregular bowel habits (564.0)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Aortic aneurysm (441.50)
☐	☐	Heart attack (410.9)
☐	☐	Stroke (435)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Arthritis (716.9)
☐	☐	Other_____

Please check those that apply to you:

☐ Pregnant ☐ Birth control pills ☐ Alcohol
☐ Tobacco use ☐ Hormone Replacement Therapy

Smoking: ___Never___Former Smoker
___Current/everyday smoker
___Current some day smoker

Medications/Supplements_____

_____

_____

_____

_____

Accidents_____

Sleep position ☐ stomach ☐ back ☐ sides

Water consumption (how much)_____

Height:_____ Weight:_____

If a family member has had any of the following please mark the appropriate box.

☐ Cancer ☐ Rheumatoid arthritis
☐ Diabetes ☐ Heart problems
☐ Lung problems ☐ Chronic back pain
☐ High blood pressure ☐ Chronic headache

Diagnosed with Diabetes: ___Type I___Type II Date:___/___/___

Been treated for Hypertension: ___Yes___No Date: ___/___/___

Hospitalizations/Surgery_____

_____

Do you have allergies(food, environmental, Medication)

List type of Allergy and Reaction:

_____

_____

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Which of the following MOST CLOSELY matches your current health goals?

☐ I am only interested in getting rid of my symptoms.
☐ I am interested in fixing the underlying cause of my current health problems.
☐ I am interested in being as healthy as I can be, and take an active interest in my health.

OUR PERSONAL CONCERN

Our professional and personal concern is your health and our reputation.
Therefore, we accept only those patients whom we sincerely believe we can help.

PATIENT SIGNATURE:_____ **DATE:**_____

Doctor's Additional Comments:_____

_____

_____