301 W. Altantic Avenue, Suite O-6, Delray Beach, FL 33444, (561) 926-9494

# My Bodyworx Inc. Health History Questionare

**Welcome!** Thank you for choosing our practice for your health needs. Your first visit to our center is an opportunity for us to learn all about you. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

## Patient Information

Name_____

DOB_____/_____/_____ Age _____

Email_____

Phone:
Home_____

Cell_____

Preferred method of communication for appointment reminders (Circle one): Email / Text

If Text - Cell phone provider_____

Preferred Language:_____

Address_____

City_____

State_____ Zip_____

❑ Married ❑ Widowed ❑ Divorced ❑ Single

# Of kids_____ Ages:_____

Employer_____

Occupation_____

Whom may we thank for referring you to us?

_____

## Health History

Have you ever been to a chiropractor before?
❑Yes ❑No Last visit? _____

Good results?_____

Have you ever been told you have any problems/defects in your spine or nervous system?

❑Yes ❑No Explain_____

Females - Pregnant? ❑Yes ❑No Due Date_____

List any types of surgeries which you have had and the dates which they occurred:

_____

_____

List any traumas and the dates which they occurred (car accidents, fall, broken bones, etc.)

_____

_____

## Daily Habits

Exercise: ❑None ❑Moderate ❑ Daily ❑Heavy

Work Activity: ❑ Sitting ❑ Standing

❑ Light Labor ❑ Heavy Labor

Smoking: ❑ Yes ❑ No ❑ Former Packs/Day_____

Alcohol: ❑ Yes ❑ No Drinks/Week_____

Caffeine/Coffee: ❑ Yes ❑ No Cups/Day_____

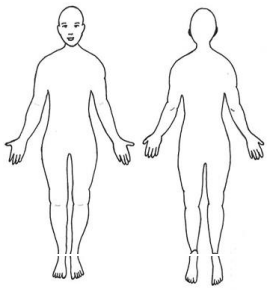
High Stress Level: ❑ Yes ❑ No Reason_____

## Patient Condition

Reason for Visit_____

_____

If you have symptoms, when did they begin?_____



Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your discomfort on a scale from 1 (least) to 10 (most) _____

Type of discomfort:
❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Aching ❑Shooting
❑Burning ❑Tingling ❑Cramps ❑Stiffness ❑Swelling ❑Other_____

How often do you have this discomfort?_____

Does it interfere with your: ❑Work ❑Sleep ❑Daily Routine ❑Recreation ❑Other_____

Activities or movements that are painful to perform:
❑Sitting ❑Standing ❑Walking
❑Bending ❑Lying Down ❑Other_____

What treatment have you already received for your condition?
❑Medications ❑Surgery ❑Physical Therapy
❑Chiropractic ❑None ❑Other_____

Symptoms are your body's way of telling you something is wrong with your health. Please check off anything that you are **currently experiencing** or have experienced **more than once in the last 6 months**.

| | | | |
|---|---|---|---|
| ❑Headaches | ❑Dizziness | ❑Fatigue | ❑Depression |
| ❑Sore Throat | ❑Neck Discomfort | ❑Low Back Discomfort | ❑Mid-back Discomfort |
| ❑Frequent Colds | ❑Ear Aches | ❑Hand/Arm Numbness | ❑Leg/Foot Numbness |
| ❑Sinus Problems | ❑Anxiety | ❑Fainting | ❑Convulsions |
| ❑Gas/Bloating | ❑Nausea | ❑Heartburn | ❑Ulcers |
| ❑Diarrhea | ❑Constipation | ❑Colitis | ❑IBS |
| ❑Hemorrhoids | ❑Walking Problems | ❑Shoulder Problems | ❑Heart Disease |
| ❑Chest pain | ❑Asthma | ❑Allergies | ❑Short breath |
| ❑Chest Congestion | ❑Lung Problems | ❑Thyroid Problems | ❑Diabetes |
| ❑Cancer | ❑Liver Problems | ❑Kidney Problems | ❑Blood Problems |
| ❑Menstrual Problems | ❑Gall Bladder | ❑Cold Extremities | ❑Bladder Problems |
| ❑Prostate Problems | ❑Infertility | ❑Extremity Weakness | ❑Extremity Swelling |

Please list any other health concerns not listed above_____

_____

How committed are you to moving yourself toward greater levels of health and wellness?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

*In compliance with federal requirements for the government electronic health records program, health care providers are required to report both race and ethnicity*

**Race (Circle one)**: American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency *(i.e. 5mg once a day)* |
|---|---|
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

❑ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____

Date:_____

## Office Use Only

Height_____ Weight_____ Blood Pressure_____

# Assignment and Instruction for Direct Payment to Doctor

## Private and Group Accident and Health Insurance

I hereby direct and instruct the _____ Insurance Company to pay by check made out and mailed directly to:

*My Bodyworx Inc.*

*301 W. Atlantic Ave, Suite O-6*

*Delray Beach, FL 33444*

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR, THEN I HEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

*My Bodyworx Inc.*

*301 W. Atlantic Ave, Suite O-6*

*Delray Beach, FL 33444*

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature of Policyholder_____ Date_____

Witness Signature_____ Date_____

# Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective. Our only practice objective is to improve vertebral subluxation, a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to improve vertebral subluxations. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Vertebral Subluxation:** A misalignment of one or more of the vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to express it's maximum health potential.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's improvement of vertebral subluxation. Our method of vertebral subluxation improvement is by specific chiropractic adjustment of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination or care, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or disorder is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

All questions regarding the doctor's objective pertaining to care in this office have been answered to my satisfaction. I have read fully and understand the above statements and I accept chiropractic care on this basis.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date

# ACKNOWLEDGEMENT OF RECEIPT OF THIS OFFICE'S PRIVACY NOTICE

I acknowledge that I have received, and/or reviewed and that I also accept the terms of the following forms: Notice of Privacy Practices, Consent for use or Disclosure of Health Information and Marketing Authorization. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the office's Privacy Practices is posted where I can review it if desired.

_____ _____ _____

Patient Name Printed Patient Signature Date

_____ _____

Minor - Parent Signature of Patient under age of 18 Date

_____

Authorized Provider Representative (Office use only)

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