BODYWORKS

CHIROPRACTIC · HEALTH · VITALITY

13900 W. Wainwright Dr. Boise ID 83713
Phone 208.376.0660 / Fax 208.938.3476

Please answer the following questions completely, Thank you!

Patient Information Form

Patient Name:_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Date of Birth: _____

Primary Phone: _____ **Work/ Secondary Phone:** _____

Place of Employment: _____ **Occupation:**_____

Email: _____

Social Security: _____

Emergency Contact Name: _____ **Phone:**_____

Gender: Male or Female **Marital Status: Single Married Partnered**

How did you hear about BodyWorks? _____

What are your hobbies?_____

Have you had Chiropractic care before? Yes No If female, are you pregnant? Yes No

Patient's Name: **Date:**

During the past 4 weeks: **None** **Unbearable**

a) Indicate the average intensity of your symptoms 0 1 2 3 4 5 6 7 8 9 10

b) How much has pain interfered with your normal work (including both work outside the home and office)

Not at all A little bit Moderately Quite a bit Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities?

Very Often Often Not Frequently Not at All

In general would you say your overall health right now is…

Excellent Very Good Good Fair Poor

Who have you seen for symptoms? And has it helped?

Chiropractor Y/N Medical Doctor Y/N Physical Therapist Y/N

a. What treatment did you receive and when?_____

b. What test have you had for your symptoms and when were they performed?

XRay Date_____ CT Scan date____ MRI Date____

Have you had similar symptoms in the past?

If yes, explain_____

_____

Social History

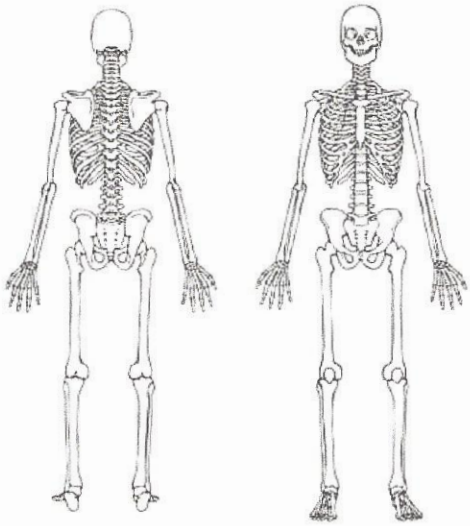
Smoker Y or N

Alcohol Y or N

Family History

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizure Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Ulcer or Stomach Problems
( ) Stroke
( ) Arthritis
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer

Indicate where you have pain or other symptoms



Is this visit due to a Worker's Compensation Claim? Y or N

If so, please fill out the following.

Date of Injury_____

Employer_____

Insurance Co_____

Policy/Claim_____

History/ Chief Complaint

Patient Name: Date:

Please list any accidents, injuries, surgeries, and major illnesses.

TYPE	MONTH/YEAR	DESCRIBE/COMMENT

Presently taking any medication?

NAME OF DRUG	AMOUNT	HOW LONG

Please circle any of the following that give you difficulty

Headaches	Sinus pain	Heart pain	Indigestion
Shooting head pain	Loss of smell	Heart palpitation	Intestinal gas
Neck Pain	Hay fever	Heart attacks	Low back pain
Grating in neck	Loss of taste	Mid back pain	Constipation
Muscle spasms	Tightness in throat	High blood pressure	Menstrual cramps
Loss of balance	Inflammation in throat	anemia	Menstrual irregularity
Fainting	Thyroid trouble	Nervous stomach	Diabetes
Tight shoulder muscles	Face flushed	Stomach trouble	Swelling
Heavy head	Face twitching	Ulcers	Arthritis
Ringing in ears	Loss of memory	Nervousness	Slipped disc
Neuritis in arms	Fatigue	Irritability	Pinched nerve
Arm and hand pain	Depression	Cold sweats	Irregular sleep
Chest pains	Weight gain	Liver trouble	Leg or feet pain
Shortness of breath	Weight loss	Gallbladder trouble	Leg or feet weakness

Describe your symptoms

_____

_____

_____

_____

When did your symptoms start?

_____

_____

How did they begin?

_____

_____

How often do you experience your symptoms?

Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

Doctor Notes

_____

Patient Name:

BodyWorks Health & Wellness Privacy Policy and Personal Health Information

At BodyWorks we are dedicated to providing our patients with the highest and most professional atmosphere possible. We will do our best to ensure that your personal health information (PHI) will not be used in any manner that is not directly related to your health care needs. BodyWorks Health & Wellness will not disclose any of your PHI without your consent as required by law. We restrict access to your PHI to those individuals who have a need to know so we can provide you our services. We maintain physical, electronic, and procedural safe guards to protect your information. We may change our policy at any time to meet regulatory or legal changes in concern for your privacy. You have the right to authorize release of your PHI and you may also revoke authorization in part of all at one time.

Permitted Disclosures

BodyWorks Health & Wellness is permitted to use and disclose your PHI for treatment, payment and healthcare operation purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, to accurately bill services we provide to you, to your insurance company for reimbursement, to remind you of an appointment and as part of our quality improvement program. We will disclose your PHI when referring you to other physicians for further health care. We will not disclose your information to any other family or friend unless otherwise listed below. Finally, we reserve the right to change a privacy practice described in this notice.

Acknowledgement

I _____ acknowledge that I have received this summary regarding the use and disclosure of my PHI. I authorize the release of any medical information necessary to process any claims, for personal use, or for any other clinic in which I am a patient. I permit a copy of the authorization to be used in the place of an original. This authorization may be revoked by me at any time in writing.

_____Date

_____Signature

Individuals we can legally release your PHI to:

Name:

_____

_____

_____

_____

_____

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Agreement to Office Policy and Rules

1.) I agree to follow my appointment schedule. I understand that I will be expected to make up any missed appointments. All *missed* appointments must be made up within seven (7) days. Failure to do so will result in a $20 no-show fee.___

2.) I agree to follow any other recommendations made by the doctor, including the proper use of spinal supports, orthotics, exercises, etc.___

3.) I understand that any recommendation for future care will be made only after physical and/or X-ray re-examination.___

4.) I agree to make a personal financial agreement and promptly fill out all necessary medico-legal and insurance forms to aid in the timely payment for my care.___

5.) I understand that if my insurance company has not paid my claim within sixty (60) days a copy of that unpaid claim will be given to me and I will be responsible to follow up on the status of payment.___

6.) Massage payments are due at the time of service.

7.) I understand that 24 hours notice is required when canceling a massage appointment. Failure to do so will result in a $20 no-show fee. I authorize my credit card to be charged in such cases.___

8.) In the event that my insurance company does not pay for any submitted claim, I will be responsible for that claim at a discounted rate of $50 per visit.___

_____ _____

Signature of Responsible Party, Parent, or Guardian Date

_____

Printed name

_____ _____

Witness (Patient name if other than responsible party Date