CURRENT HEALTH HISTORY Date:_____

Name_____ DOB_____ Age:___ □ Male □ Female

Address_____City_____State_____Zip_____

Home Phone _____Work Phone_____Cell Phone _____

SS #_____-_____-_____ Email_____

WELCOME BACK! We're glad you returned for care. Let us know how we can help (check all that apply):

- I have no complaints & would like to start a wellness program.
- I have a similar complaint as last time.
- I have a new complaint unrelated to last time.
- I would like to 'correct' my complaint and then continue on with wellness care.
- I would like to 'correct' my complaint and then stop care.
- I would like a few adjustments to feel better and then stop care.

SINCE YOUR LAST VISIT…

1) Have there been any changes to your health? YES NO Explain_____

2) Have there been any changes to your family history? YES NO Explain_____

3) Have there been any traumas, accidents or surgeries? YES NO Explain_____

Please indicate in order of importance ALL complaints you are experiencing and briefly describe.

1st Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) ____Day(s) ____Week(s) ____Month(s) ____Year(s) ***Mark areas below***

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

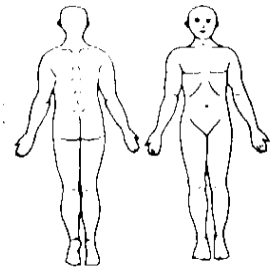
c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed Does it radiate? Yes No Where:_____

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____What makes it worse?_____



2nd Complaint_____ It's getting: Better Worse No Change

a. Been a problem for: (please specify #) ____Day(s) ____Week(s) ____Month(s) ____Year(s) ***Mark areas below***

b. Quality of symptom is: Sharp Dull Numb Tingling Burning Stiff Other_____

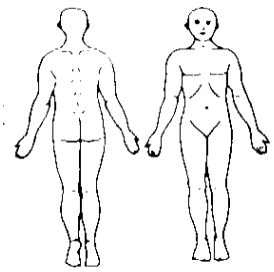
c. Condition came on: Sudden Gradual How:_____

d. It is: Constant / Frequent ***(daily)*** / Intermittent ***(several/wk)*** / Occasional ***(1/wk or less)***

e. Feels worse in: AM Noon PM In Bed Does it radiate? Yes No Where:_____

f. Rate on a scale of 1-10 *(10 = worst)* at its worst:_____

g. What makes it better?_____What makes it worse?_____



<u>Wellness Profile:</u> Chiropractic care affects more than just muscles, joints and how we feel. Chiropractic helps our bodies function at a higher level which increases our overall health and wellness. Please share with us what health goals you hope to achieve. *(Circle as many goals as you wish)*

More Energy	Better Sleep	Freedom from Pain
Easier Breathing	Improved Posture	Improved Nutrition & Diet
Improved Coordination	Eliminate Medications	Improved Overall Health
Better Sports Performance	Stress Reduction	Better Concentration
Stronger Immune System	Other_____	

Continued on back…

ACTIVITIES OF DAILY LIVING - In order to properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition currently.**

		0	1	2	3	4
1)	**Pain Intensity:**	None	Mild	Moderate	Severe	Unbearable
2)	**Frequency of Pain:**	None	25% of the day	50% of the day	75% of the day	Constant
3)	**Lifting:**	No Pain w/ Heavy Weight	Increased Pain w/ Heavy Wt.	Increased Pain w/ Moderate Wt.	Increased Pain w/ Light Wt.	Increased Pain w/ Any Wt.
4)	**Walking:**	No Pain w/ Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain w/ Any Distance
5)	**Standing:**	No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain w/ Any Standing
6)	**Travel:** (Driving)	No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips
7)	**Work:**	Do Usual Work + Unlimited Extra	Do Usual Work But No Extra	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work
8)	**Sleeping:**	Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Severely Disturbed	Totally Disturbed
9)	**Personal Care:** (Washing, Dressing, etc.)	No Pain	Mild Pain	Moderate Pain	Severe Pain	Unbearable Pain
10)	**Recreation:**	Can do All Activities	Can do Most Activities	Can do Some Activities	Can do Few Activities	Cannot do Any Activities

Score:_____

Fees & Care Plans:

Exam = $80 -$95 X-rays = $75/set Adjustments = $45-$60

Insurance: We used to be 'in network' with many insurance companies; however, we found being 'out of network' offered most of our patients' *better* coverage and *fewer* restrictions. Currently we are ***'in network'*** with **BC/BS** & **Medicare**. We are considered ***'out of network'*** for **all others**. You may call the (800) number on the back of your card to check your coverage; however, we will call to verify your chiropractic benefits and discuss them with you on your second visit when the doctor reviews your care plan.

MEDICARE – Medicare has chiropractic coverage; however, they **DO NOT** contribute towards ***exams or xrays***.

MEDICAID – Medicaid **DOES NOT** offer ANY chiropractic benefits. Fees listed above will be your full financial responsibility.

I understand that I am directly and fully responsible to BC Family Chiropractic for all fees associated with chiropractic care whether or not paid by insurance. If I have insurance, I authorize and assign all insurance benefits payable to me for services rendered if BC Family Chiropractic accepts assignment on my behalf. I authorize use of my signature below on all insurance submissions. Copies of any x-ray reports will be released upon written request; however, the original films are the sole legal property of this practice and that by law the doctor must retain these films for a period of no less than 7 years. The above information is true and accurate to the best of my knowledge.

Patient Name	Patient Signature (Parent / Guardian)	Date	Dr. Initials
_____	_____	_____	_____

Informed Consent for Female Patients: By signing below I acknowledge that I understand the hazardous effects of x-rays to an unborn child and that I am not pregnant to the best of my knowledge. The first day of my last menstrual cycle was on _____. I hereby consent to have any diagnostic x-ray exam the doctor deems necessary.

Patient Signature	Date	Dr. Initials
_____	_____	_____