Boesky Chiropractic, PLC Confidential Health History

4204 S. Westnedge Ave. Kalamazoo, MI 49008 Ph (269) 342-9090 Fax (269)342-9054

Today's Date: ___/___/_____ Legal Name: _____ Name to Call you: _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ Marital Status M S W D P

Cell Phone _____ Other Phone _____

Do you have a:

____New Symptom or Injury since last visit here?

____Recurrence or ongoing Old Symptoms or Injury since last visit here?

____ No Symptoms…just returning for care to stay well

____Other?

Please explain your symptoms or problems:

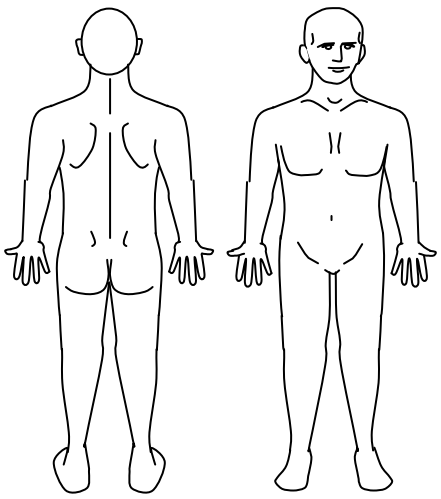
_____

_____

_____

Are you Pregnant: _____ If so, what is your due date? _____ How many weeks are you?_____

Is the baby breech or sidelying? _____



Indicate symptoms on the figures: Darken in or circle

Please check other health complaints you have or have had below

Circle C=Current I=Intermittent P=Past (over 1 year)

- ____**Neck pain** C I P _____
- ____**Upper Back Pain** C I P _____
- ____**Mid Back Pain** C I P _____
- ____**Lower Back Pain** C I P _____
- ____**Sacroiliac or Hip Pain** C I P _____
- ____**Tailbone Pain** C I P _____
- ____**Sciatica** C I P _____
- ____**Arm/Hand Numbing** C I P ___Left ___Right ___Both What area? _____
- ____**Leg/Foot Numbing** C I P ___Left ___Right ___Both What area? _____
- ____**Migraines with nausea** C I P How Often? ___Weekly ___Monthly ___Other_____
- ____Migraines-no nausea C I P _____
- ____Arm pain C I P ___Left ___Right ___Both _____
- ____Leg pain C I P ___Left ___Right ___Both _____
- ____Headaches C I P _____
- ____Muscle Spasms C I P ___Upper ___Mid Back ___Low Back _____
- ____Muscle Pain/stiffness C I P _____
- ____Dizziness C I P _____
- ____Irritability C I P _____
- ____Jaw problems/TMJ C I P _____
- ____Forgetfulness C I P _____
- ____Blurred vision C I P _____
- ____Fatigue C I P _____
- ____Ringing ears C I P _____
- ____Memory loss C I P _____
- ____Light sensitivity C I P _____
- ____Disturbed sleep C I P _____
- ____Muscle Pain (Mid-Upper) C I P _____
- ____Shoulder pain C I P _____
- ____Rib pain C I P _____
- ____Chest pain C I P _____
- ____Digestive Problems C I P _____
- ____Shortness of breath C I P _____
- ____Back stiffness C I P _____
- ____Impotence C I P _____
- ____Menstrual problems C I P _____

- Other symptoms not listed _____

_____

_____

Please Complete…Put ONLY ONE symptom or complaint in EACH BOX.

Name your worst symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? _______________________________________

What makes it Worse? _______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? _______________________________________

What makes it Worse? _______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? _______________________________________

What makes it Worse? _______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

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What makes it Better? _______________________________________

What makes it Worse? _______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

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___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? _______________________________________

What makes it Worse? _______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

ACTIVITIES DISCOMFORT SCALE

NAME: _____ DATE: _____

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Exercise					
8. Climbing Stairs					
9. Carrying					
10. Household Chores					
11. Driving					
12. Dressing					
13. Job Duties					

Are there any activites you are not able to do because of your current complains? Please list them here

_____

_____

_____

Fee Schedule:

$38 When purchased as a pre-pay package of 10 adjustments: $380

Why purchase a pre-paid package?

Prepaid packages do not expire
Prepaid packages can be shared with others in your household
Unused visits are refundable.

$47 When purchased individually

Exams & X-Rays:

Exams and X-rays on existing patients
$35 Exam
$30 for each X-Ray View

Payment terms and third party billing: Payment is due at time of service.
We do not bill to third parties such as insurance or Auto/Work companies.

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations

I acknowledge that Boesky Chiropractic, PLC "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Boesky Chiropractic, PLC Notice of Privacy Practices prior to signing this document. Boesky Chiropractic, PLC' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Boesky Chiropractic, PLC. The Notice of Privacy Practices for Boesky Chiropractic, PLC is also provided on request at the main administration desk of this practice and on Boesky Chiropractic, PLC'' website at www.chiroandy.com. This Notice of Privacy Practices also describes my rights and Boesky Chiropractic, PLC' duties with respect to my protected health information.

Boesky Chiropractic, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Boesky Chiropractic, PLC website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing below you understand and agree to our financial and HIPPA policies:

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Relationship to Patient (Self, Parent, Guardian, etc)