

Boesky Chiropractic Confidential Health History

*If your visit here is related to an auto or work injury claim, please inform us immediately.

Date ___/___/___ Name _____ Name to call you _____

Address _____ apt _____

City _____ St _____ Zip _____

Date of Birth ___/___/___ Age _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

e-mail address _____ Marital Status M S W D P

How did you hear about our office?

- Another Patient (Write their name here if we can thank them _____)
- Sign _____
- Website _____ Other _____

Employer or School _____ Occupation or Major _____

Previous Chiropractor _____ Date of Last Adjustment _____

Please write your symptoms below

(1= best 10=worst)

Symptom #1 _____	How severe is this symptom?	1	2	3	4	5	6	7	8	9	10
Symptom #2 _____	How severe is this symptom?	1	2	3	4	5	6	7	8	9	10
Symptom #3 _____	How severe is this symptom?	1	2	3	4	5	6	7	8	9	10
Symptom #4 _____	How severe is this symptom?	1	2	3	4	5	6	7	8	9	10

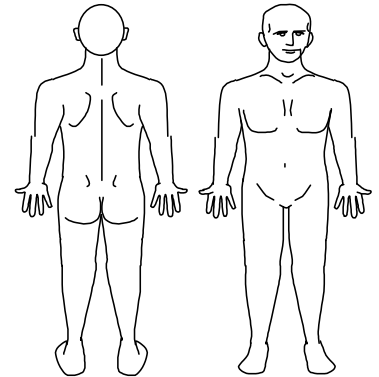
This pain began *Suddenly *Gradually **Describe here** _____

2. When did your symptoms appear? _____

Circle the answers that most closely apply to your pain or problem:

- 3. I have pain that is:** *Sharp *Achy *Dull *Shoots or Radiates
- 4. I have this symptom:** *Constantly *Intermittent *Changes with Position/Activity
- 5. My symptoms are:** *Staying the same *Worsening *Improving
- 6. I have Numbness/Tingling** Where? _____
- 7. Activity/Position that makes problem Worse?** _____
- 8. What makes the problem Better?** _____
- 9. When is the problem worse?** *Morning *Mid-day *Night *All day or night
- 10. Have you had this problem before?** _____ *When? _____
- 11. Auto Accidents** _____
- 12. Other Injuries** _____
- 13. Surgeries** _____
- 14. Medications** _____

Darken area of pain below



15. The problem affects:

- ___ My normal home/work activities
 - ___ My ability to move my body in a normal way
 - ___ My ability to drive or get around
 - ___ My mental or emotional state
 - ___ My Social or Recreational activities
- Your Height _____ Your Weight _____

Please indicate other health complaints in the columns below

	Currently	Sometimes	In the past (More than one year)
<input type="radio"/> Neck pain			
<input type="radio"/> Muscle Pain/stiffness (Neck)			
<input type="radio"/> Headaches			
<input type="radio"/> Arm/Hand Numbing			
<input type="radio"/> Dizziness			
<input type="radio"/> Irritability			
<input type="radio"/> Arm pain			
<input type="radio"/> Jaw problems/TMJ			
<input type="radio"/> Forgetfulness			
<input type="radio"/> Blurred vision			
<input type="radio"/> Fatigue			
<input type="radio"/> Ringing ears			
<input type="radio"/> Memory loss			
<input type="radio"/> Migraines			
<input type="radio"/> Nausea			
<input type="radio"/> Light sensitivity			
<input type="radio"/> Disturbed sleep			
<input type="radio"/> Upper Back Pain			
<input type="radio"/> Muscle Pain (Mid-Upper)			
<input type="radio"/> Shoulder pain			
<input type="radio"/> Rib pain			
<input type="radio"/> Chest pain			
<input type="radio"/> Digestive Problems			
<input type="radio"/> Shortness of breath			
<input type="radio"/> Lower Back Pain			
<input type="radio"/> Muscle Pain (Lower)			
<input type="radio"/> Leg/Foot Numbing			
<input type="radio"/> Sciatic Leg Pain			
<input type="radio"/> Back stiffness			
<input type="radio"/> Impotence			
<input type="radio"/> Menstrual problems			
<input type="radio"/> Sacroiliac Pain			
<input type="radio"/> Hip Pain			
<input type="radio"/> Leg pain			
<input type="radio"/> Other symptoms not listed	_____		

Office Notes Here:

Consent to treatment

Your care at our office is based on the following guidelines.
Please Read and sign below if you understand and agree to these guidelines

Diagnosis and Treatment:

Our goal is to find and eliminate a condition known as Vertebral Subluxation, spinal bones (vertebrae) that are misaligned or not in proper function. This condition usually affects the joints, muscles, soft tissues and nerve function that your body needs to maintain proper health.

The method we use is called a Spinal Adjustment, (a specific manual manipulation of your spine) to achieve the best spinal alignment and function. The desired result is to restore normal nerve, joint, and general spinal function, and therefore, better health. We may employ or recommend other methods of treatment to aid in your improvement such as Intersegmental traction, exercise, heat or cold therapy as well as providing supports for your neck and spine.

Risks and Expected Results:

Most Vertebral Subluxations take years to develop, and may not have caused recognizable symptoms until recently. In most cases Chiropractic care begins to help with your symptoms fairly quickly.

However, some cases take longer due to complicating conditions in the spine. Correcting the Vertebral Subluxations after the symptoms are relieved can take months or years of chiropractic treatment.

Spinal Adjustments may not remove your symptoms right away, and in some cases may cause pain or irritation. Other unusual side effects may occur like mild contusions, small fractures to bones, soreness or muscular pain, nerve pain or vascular events.

These effects are vary rare and the doctor may not accept your case if he feels the risks to you are unusually high.

In many cases, you may experience other health benefits that you did not know were related to the spine.

Treating symptoms and other diseases:

We are concerned with your immediate symptoms but cannot treat them directly. That is the job of medicine or an MD.

We will provide chiropractic care with the goal of restoring normal function to your spine with the desired goal being relief of pain or symptoms as your body begins to heal. In most cases, the symptoms you desire to eliminate usually improve with our care. If the cause of your symptoms is unrelated to the spine or are out of our scope of chiropractic practice we may refer you to another health professional. If we find that your problems are not treatable by chiropractic means, we may not accept your case, or may refer you to another health care professional that can help you. We will not offer advice regarding the treatment prescribed by others.

Please sign below to confirm that you understand and agree to these terms of your acceptance as a patient at this office.

Printed Name Of Patient _____

Signature _____ Date _____

Witnessed by Boesky Chiropractic _____

Insurance and Financial information

If we can verify that you have coverage for care at this office, we will be glad to bill your insurance company for you. If your insurance company does not pay, or does not pay the full amount that we billed, you will be responsible to pay the balance upon receipt of insurance denial. ***Please note verification of coverage does not guarantee payment by your insurance company. If there is a difference in the verified amount and the actual amount paid you will be responsible.**

If you need to make special arrangements for payment, please let us know before you see the doctor today. Thank you!

First Health Insurance Company _____

Policy Number _____ Employer or Group # _____

If not your own name, who's name is the policy under? _____

What is this person's relationship to you? ___ Spouse ___ Parent

What is this person's date of birth? ___/___/_____

Second Health Insurance Company _____

Policy Number _____ Employer or Group # _____

If not your own name, who's name is the policy under? _____

What is this person's relationship to you? ___ Spouse ___ Parent

What is this person's date of birth? ___/___/_____

Please check one below:

"I will pay cash for my care."

"I understand that payment is due at time of service unless other written arrangements are made in advance".

"Bill my insurance for my care and I agree to pay what they reject"

"I understand that my insurance coverage is a contract between me and my insurance company. If my insurance does not pay, or does not pay in full, I agree to pay the balance due at the time of insurance denial."

Print your name here _____

Sign here _____ Date _____

Witnessed by Boesky Chiropractic _____

A note about your records at this office:

According to Michigan law, your health records, including all x-rays are the permanent property of our office. You are entitled to the information contained within your records but we cannot release your records directly to you. Copies of your x-rays can be made by us at a facility that performs this service, and given to you for a fee. If another physician requests your x-rays in writing from our office we will send them to that physician and they will be returned to us by that office. Thank you

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that **Boesky Chiropractic's** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Boesky Chiropractic's** Notice of Privacy Practices prior to signing this document. **Boesky Chiropractic's** 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**. The Notice of Privacy Practices for **Boesky Chiropractic** is also provided on request at the main administration desk of this practice and on **Boesky Chiropractic's** website at www.chiroandy.com. This Notice of Privacy Practices also describes my rights and **Boesky Chiropractic's** duties with respect to my protected health information.

Boesky Chiropractic 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's** 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.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority