BestLife
CHIROPRACTIC AND WELLNESS CENTER

5072 W. Plano Pkwy., Ste 130, Plano, TX 75093 (972) 200-5009
4401 Long Prairie Rd., Ste 200, Flower Mound, TX 75028 (972) 539-7500

Welcome to our office! *PLEASE PRINT AND COMPLETE ALL SECTIONS*

Appointment Date: _____ Referred By: _____
Name (first, middle, last) _____Preferred Name: _____
Mailing Address_____ City_____ State_____ Zip_____
Home (____)_____ Work (____)_____ Cell (_____)_____ Preferred Method _____
Social Security # _____ Date of Birth___/___/_____ Age_____ □Male □Female
Email: _____
Occupation_____Employer_____
Marital Status: □M □S □W □D Name of Spouse:_____
Names and Ages of Children: _____
Emergency Contact: _____ Relationship:_____ Phone: ( )_____

CONSENT TO X-RAY EXAMINATIONS
If and when deemed necessary, I do hereby consent to x-ray examination.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.
Last Menstrual Period Date _____

Signature of Responsible Person: _____ Date: _____

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize Drs. Steven and Laura Le, licensed Doctors of Chiropractic in the state of Texas, to administer treatment as deemed necessary to my Son/Daughter/Other: _____

Child's Name: _____

Signature of Guardian: _____ Date: _____

Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

- Risk of stroke is reported to be 1 in 5-8 million or so... and the cause has yet to be determined.
- While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
- There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for me and my family.

Patient Name _____ **Date _____**

Signature_____ **Witness _____**

HIPAA Consents

Name of Practice: **Best Life Chiropractic and Wellness Center**
Address: 5072 W. Plano Parkway, Ste. 130 and 4401 Long Prairie Rd., Ste. 200
Plano, Texas 75093 Flower Mound, Texas 75028
Privacy Contact: Steven Le, D.C.
Telephone: 972-200-5009

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

NOTICE OF PRIVACY PRACTICE RECEIPT:
I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: X_____
Signature of Patient: X_____
Date: X_____
Patient's Date of Birth: X_____

For Personal Representative of the Patient (only if applicable)

Print Name of Personal Representative: X_____
Relationship (parent, guardian, etc.): X_____
Signature of Personal Representative: X_____
Reason Patient unable to sign: _____

_____ _____
Practice Employee Date

ALL PATIENTS PLEASE PROVIDE THE FOLLOWING
May we release appointment, billing and medical information to anyone other than you? ___YES ___NO

Name(s) of the person(s) we may release your information to: _____

* I hereby authorize Best Life Chiropractic and Wellness Centers to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.
* I authorize the release of any medical billing or other information necessary to process claims on my behalf.
* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Best Life Chiropractic and Wellness Center, Plano and Flower Mound, Texas.

_____ _____
Signature of Patient Date

_____
Print Name

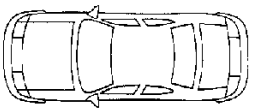
Please initial one box below:
If our office attempts to contact you and a message is taken by an answering machine/voicemail or another person, it is appropriate to leave a:
____ Detailed message regarding condition, appointments, or payments.
____ Message to call Best Life Chiropractic and Wellness Center

Auto Accident History Questionnaire

BestLife CHIROPRACTIC AND WELLNESS CENTER
5072 W. Plano Pkwy, Suite 130 Plano, TX 75093
Phone: (972) 200-5009 Fax: (972) 248-9292

Patient Name _____ **Date** _____

1. Date of Accident: _____ Time of Accident: _____ AM/PM
2. Driver of Car: _____
3. Where were you seated? _____
4. Who owns the car? _____
5. Year, Make, & Model of your car: _____
6. Year, Make, & Model of other car: _____
7. Visibility at time of accident: ☐ poor ☐ fair ☐ good ☐ other: _____
8. Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dark ☐ other: _____
9. Where was your car struck?

Front  Rear

In your own words, please describe the accident in detail: _____
_____
_____

10. Type of accident: ☐ Head-on collision ☐ Broad-side collision ☐ Front impact
☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
11. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car:
_____
12. Did you see the accident coming? ☐ yes ☐ no
13. Did you brace yourself for the impact? ☐ yes ☐ no
14. Were seatbelts worn? ☐ yes ☐ no
15. Were shoulder harnesses worn? ☐ yes ☐ no
16. Does your car have headrests? ☐ yes ☐ no
17. If yes, what was the position of those headrests compared to your head before the accident?
☐ Top of headrest even with **bottom** of head
☐ Top of headrest even with the **top** of head
☐ Top of headrest even with **middle** of the neck
18. Was your car braking? ☐ yes ☐ no
19. Was your car moving at the time of the accident? ☐ yes ☐ no
20. If yes, how fast would you estimate you were going? _____ mph
21. How fast would you estimate the other car was going? _____ mph
22. Head/Body position at the time of impact:
☐ Head turned left/right ☐ Body straight in sitting position
☐ Head looking back ☐ Body rotated right/left
☐ Head straight forward ☐ Other: _____
23. As a result of the accident were you:
☐ Rendered unconscious
☐ In shock

□ Dazed, circumstances vague

□ Other: _____

24. How was the shoulder harness adjusted? □ Loose □ Snug
25. Were you wearing a hat or glasses? □ yes □ no

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26. Could you move all parts of your body? □ yes □ no
27. If no, what parts couldn't you move and why? _____
28. Were you able to get out of the car and walk unaided? □ yes □ no
29. If no, why not? _____
30. Did you get any bleeding cuts? □ yes □ no If yes, where? _____
31. Did you get any bruises? □ yes □ no If yes, where? _____
32. Please describe how you felt…
    Immediately after the accident: _____
    Later that day: _____
    The very next day: _____
33. Check symptoms apparent since the accident:

□ Headache	□ Neck pain/stiffness	□ Mid-back pain
□ Eyes light sensitive	□ Pain behind eyes	□ Dizziness
□ Fainting	□ Sleeping problems	□ Numbness in fingers
□ Numbness in toes	□ Loss of smell	□ Loss of taste
□ Loss of memory	□ Fatigue	□ Breath shortness
□ Irritability	□ Depression	□ Ringing/Buzzing
□ Loss of balance	□ Tension	□ Cold hands
□ Cold feet	□ Diarrhea	□ Constipation
□ Chest pain	□ Nervousness	□ Cold sweats
□ Anxious	□ Facial pain	□ Clicking or popping in jaw
□ Low-back pain	□ Other: _____	

34. Occupation: _____ Employer: _____
35. Have you missed time from work? □ yes □ no
36. If yes, full time off work: _____ to _____
37. If yes, part time off work: _____ to _____
38. Did you seek medical help immediately after the accident? □ yes □ no
39. If yes, how did you get there? □ Ambulance □ Police □ Someone else drove me
    □ Drove my own car □ Other: _____
40. Doctor #1 seen: _____ Location: _____
41. First visit date: _____
42. Were you examined? □ yes □ no Were x-rays taken? □ yes □ no
43. Did you receive treatment? □ yes □ no

44. If yes, what kind of treatment did you receive? ☐ Medications ☐ Braces ☐ Collars ☐ Other: _____
45. What benefits did you receive from the treatment? _____
46. Date of last treatment: _____
47. Doctor #2 seen: _____ Location: _____
48. First visit date: _____
49. Were you examined? ☐ yes ☐ no
50. Were x-rays taken? ☐ yes ☐ no
51. Did you receive treatment? ☐ yes ☐ no
52. If yes, what kind of treatment did you receive? ☐ Medications ☐ Braces ☐ Collars ☐ Other: _____
53. What benefits did you receive from the treatment? _____
54. Date of last treatment: _____
55. Do you have an attorney on this claim? ☐ yes ☐ no
56. If yes, who? _____ Phone _____
    Address _____ City _____ State _____ Zip _____

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Illustrate below how the accident happened

57. Past medical history: (Place an "x" if applicable, and describe) ☐ None related to current complaints ☐ Hospital or operation ☐ Auto accident ☐ Work accident ☐ Illness ☐ Other
    Describe: _____
    _____
    _____
58. Family history: (Place an "x" if any family member has suffered from:)
    - ☐ Tuberculosis ☐ Kidney Disease ☐ Spinal disorder
    - ☐ Mental Illness ☐ Epilepsy ☐ Diabetes
    - ☐ Gout ☐ Allergy ☐ Arthritis
    - ☐ Hypertension ☐ Cancer ☐ Migraines
    - ☐ Heart Attack ☐ Other: _____
59. Are you: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/Widower

60. Number of children: _____ Number of children at home: _____
61. Is your spouse employed? ☐ yes ☐ no
62. Are you pregnant? ☐ yes ☐ no
63. Medications you are on, describe: _____
_____ Diseases, describe: _____
_____ Other health history, describe: _____
_____

Patient Signature _____ **Date:** _____

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CURRENT CHIEF COMPLAINT(S):

Place an "x" in the appropriate complaint areas.

SPINE

☐ Low back	☐ Mid back	☐ Neck	☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L	☐ Arm R/L	☐ Elbow R/L
☐ Wrist R/L	☐ Forearm R/L	☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L	☐ Thigh R/L	☐ Knee R/L
☐ Leg R/L	☐ Ankle R/L	☐ Foot R/L

OTHER (describe):
_____
_____

SUBJECTIVE PAIN LEVEL:

On a scale of 1 to 10, place an "x" in your

current pain level.

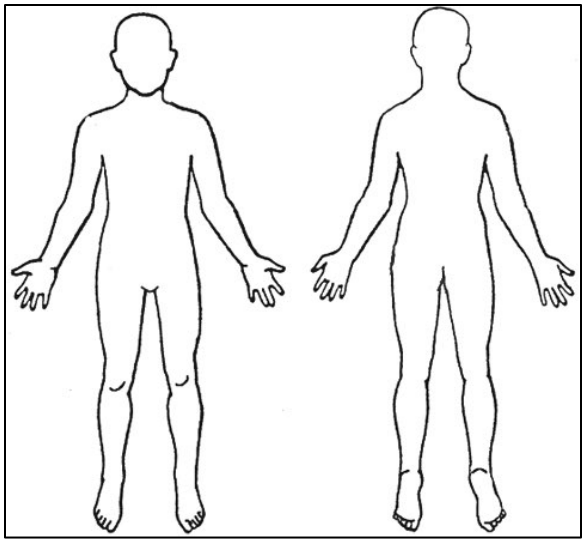
NORMAL
□ 0

LOW PAIN
□ 1 □ 2 □ 3

MODERATE PAIN
□ 4 □ 5 □ 6

INTENSE PAIN
□ 7 □ 8 □ 9

EMERGENCY
□ 10



Mark the areas on your body where you feel the described sensations. Using the appropriate symbols mark stress points of radiation. Please include all affected areas.

X NUMBNESS **+** BURNING **O** PINS & NEEDLES **=** STABBING

Patient Signature: _____ Date: _____