BestLife
CHIROPRACTIC AND WELLNESS CENTER

Welcome to our office!

Please fill out our health record as completely and accurately as possible. If you have any questions, please don't hesitate to ask one of our staff members. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with chiropractic care.

About this Patient

First Name: _____ **Last Name**: _____

Date of Birth: _____/_____/_____ **Gender**: ◯ Male ◯ Female ◯ Other

Cell Phone: (_____) _____ **Home Phone**: (_____) _____

Street Address: _____

City: _____ **State/Province**: _____ **Zip Code**: _____

Social Security #: _____ **Email**: _____

How did you hear about us? _____

Occupation: _____ **Employer**: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Name of Spouse: _____ **Spouse's Cell Phone**: (_____)_____

Name and Ages of Children:

_____

Emergency Contact First Name: _____

Emergency Contact Relationship: _____ **Emergency Contact #:** (_____)_____

Health Insurance

Insurance Company: _____

Provider Services Phone Number (on back of card): (_____)_____

Member ID #: _____ **Group #:** _____

Insured's First Name: _____ **Insured's Last Name**: _____

Insured's Social Security #: _____

Insured's Date of Birth: _____/_____/_____ **Relation to Insured**: _____

Experience with Chiropractic

Have you been to a chiropractor before? ◯ Yes ◯No

Chiropractor's Name:_____ **Approximate date of last visit?** ____/_____/_____

Reason for those visits? _____

Health Habits

Do you smoke?

◯ Yes ◯ No

Do you drink alcohol?

◯ Yes ◯ No

Do you drink caffeine?

◯ Yes ◯ No

Are you on any special diets?

◯ Yes ◯ No **If yes, please explain:** _____

How often do you exercise? _____

FOR WOMEN ONLY:

Are you pregnant? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No

Do you have breast implants? ◯ Yes ◯ No

Are you on birth control? ◯ Yes ◯ No

Do you experience painful periods? ◯ Yes ◯ No

Do you have irregular cycles? ◯ Yes ◯ No

TELL US ABOUT YOUR HEALTH GOALS

What are your expectations of this office?

_____

How do you want us to approach your care?

◯ Temporary Relief (help the symptom, but do not fix the cause)

◯ Maximum Correction (correct the cause for maximum stability in the future)

Things I do currently to support my health include:

◯ Drink plenty of water ◯ Exercise ◯ Acupuncture

◯ Meditate ◯ Yoga/Pilates/Aerobics ◯ Vitamins, minerals or herbs

◯ Massage Therapy ◯ Counseling/Therapy ◯ Annual physical exams

◯ Other ◯ Nothing

If other was selected, please explain:

_____

Please list any vitamins or supplements you are currently taking:

_____

Health Conditions

Please check each of the diseases or conditions that you have had now or in the past.

Health Conditions:

◯ ADHD Autism ◯ Congenital Heart Defect ◯ Shingles

◯ Neck Pain ◯ Heart Surgery/Pacemaker ◯ Anemia

◯ Lower Back ◯ High/Low Blood Pressure ◯ Headaches/Migraines

◯ Pain Pinched Nerve ◯ Psychiatric Diagnosis ◯ Arthritis

◯ Numbness or Pain in ◯ Kidney Disorder ◯ Diabetes

Arms/Legs/Hands/Feet ◯ Digestive Issues ◯ Asthma

◯ Heart Attack/Stroke ◯ Allergies ◯ Chest Pain

◯ Thyroid Disorder ◯ HIV/AIDS ◯ Depression/Anxiety

◯ Sleep Issues ◯ Infertility ◯ Cancer

◯ Scoliosis ◯ Autoimmune Disease ◯ Ear Infection

Other If other, please specify:

_____

Medical and Family History

Are you currently taking anti-coagulant/blood thinning medication? ◯ Yes ◯ No

List prescription and non-prescription drugs you take:

_____

List any allergies: _____

List any major illnesses or medical diagnoses: _____

List any past hospitalizations: **List any surgeries:**

_____ _____

Please indicate if a family member or spouse has a history of the following conditions:

◯ ADHD	◯ Allergies	◯ Arthritis	◯ Asthma
◯ Back Pain	◯ Cancer	◯ Chest Pain	◯ Depression
◯ Diabetes	◯ Chronic Ear Infection	◯ Epilepsy	◯ Migraines
◯ Heart Trouble	◯ High/Low Blood Pressure	◯ Infertility	◯ Kidney Trouble
◯ Autoimmune Disease	◯ Scoliosis	◯ Other (list below)	◯ Neck Pain

Please specify which family member(s) the condition(s) apply to:

_____

TELL US ABOUT YOUR PRESENT AND PAST HEALTH CONDITION(S)

PRIMARY COMPLAINT:

What is your Primary Complaint?

_____

When did this complaint begin? _____

How would you rank this complaint on a pain scale from 1 to 10; 10 being most painful? _____

Overall frequency of complaint (choose one):

◯ Constant - 100% of the time ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Does the problem interfere with the following?

◯ Family ◯ Work ◯ Hobbies ◯ Sleep ◯ None

Please select each applicable description of this complaint:

◯ Aching ◯ Tight ◯ Burning ◯ Sharp ◯ Numbing ◯ Tingling ◯ Dull ◯ Weak ◯ Shooting ◯ Other

If other was selected, please explain: _____

What makes this concern better? _____

What makes this concern worse? _____

Since it began, has your complaint: ◯ Worsened ◯ Improved ◯ Stayed the Same

Please select all that you have done so far to help your complaint:

◯ Medicine ◯ Physical Therapy ◯ Exercise ◯ Rest ◯ Ice ◯ Heat ◯ Massage ◯ Chiropractic Adjustments

◯ Yoga ◯ Surgery ◯ Psychiatrist/Psychologist/Counseling ◯ Other Healthcare Provider ◯ Nothing

If you had surgery regarding this complaint, please describe here:

_____

SECONDARY COMPLAINT:

What is your Secondary complaint (if applicable)?

_____

When did this complaint begin? _____

How would you rank this complaint on a pain scale from 1 to 10; 10 being most painful? _____

Overall frequency of complaint (choose one):

◯ Constant - 100% of the time ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Please select all that you have done so far to help your complaint:

◯ Medicine ◯ Physical Therapy ◯ Exercise ◯ Rest ◯ Ice ◯ Heat ◯ Massage ◯ Chiropractic Adjustments

◯ Yoga ◯ Surgery ◯ Psychiatrist/Psychologist/Counseling ◯ Other Healthcare Provider ◯ Nothing

Is there anything else we need to know about this complaint? _____

TERTIARY COMPLAINT:

What is your Tertiary Complaint (if applicable)?

_____

When did this complaint begin? _____

How would you rank this complaint on a pain scale from 1 to 10; 10 being most painful? _____

Overall frequency of complaint (choose one):

◯ Constant - 100% of the time ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Please select all that you have done so far to help your complaint:

◯ Medicine ◯ Physical Therapy ◯ Exercise ◯ Rest ◯ Ice ◯ Heat ◯ Massage ◯ Chiropractic Adjustments

◯ Yoga ◯ Surgery ◯ Psychiatrist/Psychologist/Counseling ◯ Other Healthcare Provider ◯ Nothing

Is there anything else we need to know about this complaint? _____

_____ _____

Signature **Date Signed**

_____ _____

Printed Name **Email**

Media Consent Form

I DO or DO NOT consent for Best Life Chiropractic's staff members to take photographs of me while in the office. I understand that Best Life Chiropractic may release photos of me on its website, social media, or other publications. I understand that Best Life Chiropractic will never disclose any personal information upon posting this content.

I DO or DO NOT consent for Best Life Chiropractic's staff members to take video images of me while in the office. I understand that Best Life Chiropractic may release video images of me on its website, social media, or other publications. I understand that Best Life Chiropractic will never disclose any personal information upon posting this content.

I ___ consent to my images being released

◯ DO ◯ DO NOT

I ___ consent to my video images being released

◯ DO ◯ DO NOT

Release and Consents

AUTHORIZATION FOR DIAGNOSIS AND TREATMENT

I authorize Best Life Chiropractic to administer diagnosis and treatment as deemed necessary by the doctors.

CONSENT TO X-RAY EXAMINATIONS

If, and when deemed necessary, I do hereby consent to an x-ray examination.

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 I 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

Females Only: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.

Date of last menstrual period: _____/_____/_____

_____ _____

Signature **Date Signed**

_____

Printed Name

Authorization for Assignment of Benefits

- I authorize my insurance company(s) to pay Best Life Chiropractic & Wellness Center, LLC all insurance benefits due to me for services rendered.

- I authorize the use of this signature on all insurance submissions, including all insurance submissions for family members for whom I am the insured party.

- I authorize Best Life Chiropractic & Wellness Center, LLC to release any information necessary to my insurance company to secure the payment benefits.

Let's clarify the financial aspects of your care so we can direct all our attention to balancing your body.

We are in-network with most BCBS (non-HMO), United Healthcare, UMR, Medicare, Cigna, and Aetna (Plano Office Only) policies. Flower Mound office will accept Aetna but are not in-network. We will verify your insurance benefits and discuss your options with you. If you do not have insurance benefits, our regular fees for the **first visit** are as follows:

- Examination: $35-$75
- First and Subsequent Adjustments: $40-$65
- Best Life X-Ray Series: $75 (Or $25 per single view)
- After-Hours Adjustment or Adjustment During Labor: $100 (travel over 10 miles may be charged extra)
- Kinesiotape and/or Rocktape: Small Extremity $15, Large Extremity (Including Abdominal Region) $30
- Decompression: $85
- Rebuilder: $15

I understand that I am financially responsible for all charges incurred in this office, whether they are covered by my insurance company or not.

_____ _____

Signature **Date Signed**

_____

Printed Name

HIPAA Consent

May we release appointment, billing and/or medical information to anyone other than you, including a spouse?

◯ Yes ◯ No

If yes, who? _____

If our office attempts to contact you and a message is taken by an answering machine/voicemail, our staff should leave a:

◯ Detailed message regarding condition, appointments, or payments

◯ Message to call Best Life Chiropractic with no specific details

* 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.
** 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:

By signing this form electronically, I acknowledge that I was provided with the notice of privacy practices of the chiropractic practice named at the top of this page.

_____ _____

Signature **Date Signed**

_____

Printed Name