Patient Health History

Today's Date [. .] **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Last Name** _____

Address _____**City**_____**State**_____**Zip**_____

Mobile Phone _____**Work Phone** _____

Email _____**Home Phone**_____

Social Security Number_____**Date of Birth**_____/_____/_____**Age**_____

Emergency contact_____**Relation**_____**Phone**_____

Primary Care Physician_____**Date of last Physical**_____

Occupation_____**Employer**_____

Employment status: ❑ Employed ❑ FT student ❑ PT student ❑ Retired ❑ Disabled

Were you referred to our office? ❑ No ❑ Yes, by whom?_____

If not referred by someone, how did you hear about us?_____

Do you have any of the following? ❑ HSA ❑ Flex ❑HRA ❑Yes, but not sure which ❑None

Person responsible for your account: ❑Self ❑Parents ❑Other_____

Insurance Policy Holder: ❑**Self** ❑**Other**_____ **DOB**___/___/_____ **SSN**_____

Verification Question *(choose only one question by checking the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?

Verification Answer to the Chosen question: _____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Do you consume alcohol? ❑ No ❑ Yes How may drinks per week? _____

Do you exercise? ❑ No ❑ Yes How may times per week? ❑ Cardio____❑ Weights____❑ Other_____

Height:_____ **Weight:**_____**lbs Last blood pressure reading:** _____/_____**Date**___/___/_____

Has any doctor diagnosed you with hypertension presently? ❑ No ❑ Yes

List any known drug allergies below. If no allergies are known, check here: ❑ **NKDA**

1) _____ **3)** _____

2) _____ **4)** _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

Do you have any kids? ❑ No ❑ Yes What are their ages? _____

If female, are you pregnant? ❑ No ❑ Yes Due date: __/__/____ ❑ Not sure, Date of last period__/__/____

Have you had an X-ray, CT, or MRI of you lumbar spine (low back) in the past 28 days? ❑ No ❑ Yes

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any hospitalizations and/or surgeries you have had: ❑ None

1) _____ 3) _____

2) _____ 4) _____

For what problem(s) are you seeking our help: _____

_____

Have you seen anyone else for this? ❑ No ❑ Yes, If yes please list below:

Name_____ **Specialty**_____**Phone number**_____

Name_____ **Specialty**_____**Phone number**_____

Name_____ **Specialty**_____**Phone number**_____

Name_____ **Specialty**_____**Phone number**_____

Have you ever had this in the past? ❑ No ❑ Yes **When?** _____

Do you have a family history of this problem? ❑ No ❑ Yes **Whom?**_____

Have you seen a Chiropractor ever before? ❑ No ❑ Yes **Whom/When?**_____

Do you have any other known health conditions? _____

_____

RELEASE OF INFORMATION

INFORMED CONSENT & AUTHORIZATION TO TREAT

I, the undersigned, hereby authorize Back & Body Wellness, and any designated employees or interns to perform diagnostic procedures and render treatment. Diagnostic procedures include any procedures that may aide the doctors to form a diagnosis, evaluation, and treatment plan, and may include but not be limited to physical, neurological, orthopedic, laboratory and radiological examination. Treatment includes, but is not limited to, joint manipulation, physiotherapies, acupuncture/dry needling, and any supportive measures within the scope of practice of the doctors and their employees.
I hereby certify that I read and understand the authorization to treat and am aware of treatment advantages, as well as complications, if any, alternative forms of treatment, and that no guarantee has been made.

NAME: _____

SIGNED_____ DATE:___/___/_____

CONSENT TO TREATMENT OF A MINOR CHLD

I hereby authorize Back & Body Wellness and designated employees and interns to diagnose and treat as described above, my son, daughter, or dependent: _____ (minor's name). I hereby certify that I am the parent or legal guardian of the above named minor.

NAME: _____

SIGNED_____ DATE:___/___/_____

RELEASE OF INFORMATION

I hereby authorize the release of any and all of my medial records to Back & Body Wellness, or a representative thereof. Please Fax records to: (402) 778-1200.
I hereby authorize Back & Body Wellness to release any and all medical records pertaining to my treatment to other health care professionals or attorneys as needed. A copy or fax of this authorization shall be considered as effective and valid as the original. It shall remain effective until I revoke it with written authorization. I hereby certify that I have read and understand the above release of information.

NAME: _____ DOB:__/__/_____

SIGNED_____ DATE:___/___/_____

I, _____ (patient's name) acknowledge that I can request a copy and agree to the Notice of Privacy Practices of Back & Body Wellness, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Patient Consent to Use and Disclose Health Information
(Consent for Purposes of Treatment, Payment and Healthcare Operations)

I consent to Back & Body Wellness ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health or condition, the provision of health care to me, or reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but that Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing at any time, except to the extent that Physician of the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority