

Patient Health History

Today's Date ____/____/____ Patient Name _____

Suffix _____ Nick Name _____ Date of Birth ____/____/____ Age _____

Briefly list your main health problems/concerns: _____

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

Best Email _____ Is this a work? or home email?

I authorize my doctor to contact me via the email address(s) provided and to send me my treatment plan as needed. Yes _____

Address _____

City _____ State _____ Zip Code _____

Home Ph. _____ Work Ph. _____ Cell Ph. _____

Preferred Contact Method Home Phone Mobile Phone Email Text

Employment Status (check one)

Employed Student (full time) Student (part time) Retired Self Employed Other

Place of Employment _____ Position _____

Job Duties (sitting, standing, twisting) _____

Do you have Health Insurance Yes No If Yes, name of Insurance Company _____

Is your deductible met? Yes No Do you have a Co-Pay Yes No Amount? \$ _____

Preferred Language (check one)

English Spanish American Sign Language Russian Polish German French

Verification Question (choose only one question by circling 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?
 What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
 What was the make of your first car? When is your anniversary? Answer _____

Do you currently use tobacco or marijuana? Yes Former smoker (years? __) Never smoked Chew

If yes, how often do you use: Chew Smoke Every day Occasional Sporadically

If yes, what is your level of interest in quitting smoking? If you smoked, how long since you quit? _____

No interest 0 1 2 3 4 5 6 7 8 9 10 Very Interested

Signature _____ Date ____/____/____

How did you find us? Internet Search on Google Bing Yelp Facebook Other _____

If you were referred by someone, may we thank them? Who was it? _____

Thank you, please complete page two 😊

Name _____ Date ____/____/____

Current medications, including frequency and dosage - if there are no current medications - check here:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Supplements/Vitamins and non-prescription drugs (aspirin, ibuprofen, Tylenol) - if none, check here

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

List any known allergies you have had to any medications. If no allergies are known, check here:

- 1) _____ 2) _____
- 3) _____ 4) _____

Do you use Alcohol or any drugs? Yes No If yes, please describe _____

Has any doctor diagnosed you with Cancer, Heart Disease, Diabetes or Osteoporosis? Yes No

Please describe: _____

Have you had an X-ray, CT scan or MRI of your low back or spine in the past 28 days? Yes No

I certify that to the best of knowledge; the above information is accurate and complete. I agree to notify the clinic immediately whenever I have changes in my health conditions. I understand that my chiropractor may need to contact my other physicians if my condition needs to be co managed, therefore I give authorization to my chiropractor to contact my other physicians as necessary.

Signature _____ **Date** ____/____/____

Intake Sheet & Progress Form

Today's Date ___/___/___ Date of Injury ___/___/___ - New Injury? Auto or Work Injury -Yes, - No
 Name _____ Email _____ Cell Ph. () _____

On the figures below, please mark the areas where you feel pain or discomfort. Include all affected areas.
 If your pain radiates, draw an arrow from where it starts to where it stops.

Symbols to use

Ache: >>>

Cramping: +++

Numb: ===

Tingling: 000

Burning: XXX

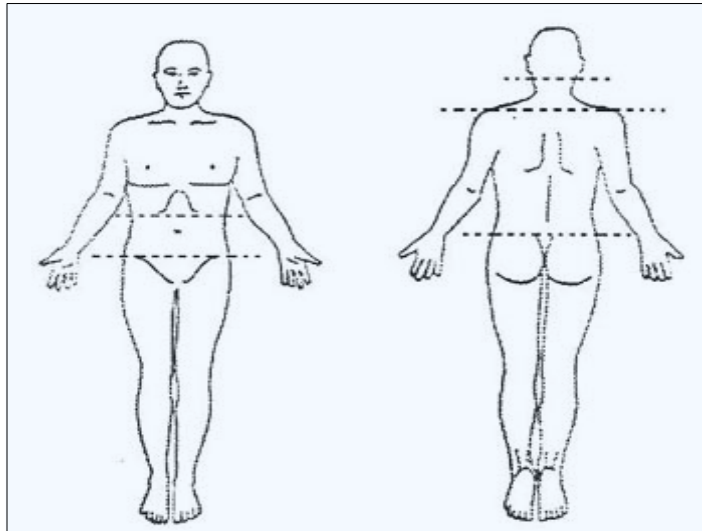
Stabbing: /////

Throbbing: ~~~

Age _____

Height _____

Weight _____



What makes symptoms worse?

Sitting	Standing
Lifting	Bending
Walking	Driving
Reaching	Twisting
Other? _____	

What makes symptoms better?

Chiropractic	Massage
Ice	Heat
Sitting	Standing
Lying down	Rest
Movement	Stretching
Other? _____	

How long has the pain or problem been present?

Please Explain _____

Is there anything that is prolonging your recovery?

Joint replacement surgery?

Yes - No -

Left ___ Right ___

Knee Hip Shoulder Other

Please place an X (or a range of X's) on the line below representing the pain or symptoms you are experiencing today.

Pain Free |-----| Worst Pain Possible

Please place an X on this line to represent the highest level of pain or other symptoms over the last week or two?

Pain Free |-----| Worst Pain Possible

Please place an X on this line to rate your ability to function at your job.

Complete Function |-----| No Function

How much has pain or other symptoms limited your daily activities?

No Interference |-----| Unable to do any activities

Which daily activities are limited? _____

In the past week, have your symptoms been present: 0-25% 26-50% 51-75% 76-100% of the time?

Is there anything you would like to add about your condition that would be helpful for us to know?

Please explain _____

Initial Health Status

Date ___/___/___

Name _____ Date of Birth ___/___/___ New Injury? Yes - No

The following information will help us treat you in the most thorough and complete way.
Please fill out this form completely and bring anything that concerns you to our attention.

Please check all of the following that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> Recent fever | <input type="checkbox"/> Currently pregnant (due date ___/___/___) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Marked morning pain/stiffness |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pain unrelieved by position or rest |
| <input type="checkbox"/> Head injuries or concussion(s) | <input type="checkbox"/> Pain at night |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> Epilepsy/seizures |
| <input type="checkbox"/> Weight <input type="checkbox"/> - Gain <input type="checkbox"/> - Loss, how much? _____ | <input type="checkbox"/> Weakness in legs or arms |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Sleeping troubles |
| <input type="checkbox"/> Dizziness/fainting/loss of balance | <input type="checkbox"/> Fatigue, low energy, or depression |
| <input type="checkbox"/> Numbness in groin/buttocks | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Frequent colds or illnesses |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tension/irritability |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Medications – Ask for Supplement Form |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Surgeries _____ |
| <input type="checkbox"/> Other health problems (explain) _____ | _____ |

Problems with: eyes ears nose throat asthma chronic cough other? _____

Heart: stent bypass angioplasty history of angina arrhythmia heart surgery other

Digestive: reflux IBS GERD colectomy other gastric surgery gluten/celiac _____

Family history of: cancer diabetes heart problems cholesterol other _____

Children: ages ___ ___ ___ boys girls both Do your kids receive regular chiropractic care? _____

Are you under stress at work or at home? Y N Do you participate in any stress reduction activities such as:
Meditation - massage yoga creative visualization or other? _____

How long has it been since you felt REALLY healthy? _____ On a scale of 0 to 100, where 0 is nearly dead and 100 is optimum health, what number is your health today? _____ Where would you like to be? _____

We are sorry to subject you to all of these forms, but thank you for filling them out! By having this information, we will be able to help you more quickly and efficiently. Again, Thank You for choosing Good Health Naturally.

I certify to the best of knowledge, the above information is complete and accurate. I agree to notify the clinic and my chiropractor immediately whenever I have changes in my health condition(s). I understand that my chiropractor may need to contact my other physician(s) if my condition needs to be co-managed, therefore I give authorization to my chiropractor to contact my other physician(s), as necessary.

Patient Signature _____ Date ___/___/___



Relief Today,
Better Health Tomorrow

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A clear definition of our policies will allow us both to concentrate on the big issue of regaining and maintaining your health.

CONSENT TO TREAT

Any medical or chiropractic care has potential risks. The chiropractic care, massage therapies and modalities used at Good Health Naturally, PLLC have been carefully evaluated for safety and effectiveness. The risks of injury are extremely low however if you have special needs or any concerns about treatment at this clinic, please ask Dr. Blessley or any staff member for clarification and/or more information on our treatments or policies.

I have read and understand the above statement and hereby give my consent to treatment. Initials

INSURANCE

Co-payments will be collected at the time of service. We will bill your insurance company for you, but ultimately you are responsible for any fees not covered by your insurance company. If you have an unmet deductible, a partial or full payment will be required at the time of service.

TOS (Time of Service Discount)

A 20% discount on fees is available for Chiropractic Care if the full amount is paid at the time of service (or in advance). This program is available for all patients and insurance companies who pay at the time of service. Ask.

WORKERS COMPENSATION and PERSONAL INJURY

We will fill out necessary forms and submit them through proper channels after we receive information from you.

SPECIAL NEEDS/HARDSHIP CASES

Special needs and/or hardship cases may receive treatment at a discount or at no charge. Retail items are not included. A statement of hardship will be required to be signed and kept in patients file and another may be required from a counselor, priest/minister or other person having knowledge of the hardship situation.

Our office will provide insurance billing services for you as a courtesy. Please know that your health insurance benefits are based on a contract between you and your health insurance carrier and any benefits quoted are not a guarantee of payment. Final determination of payment will only be made after claims have been received and processed. Remember that you as a patient are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances that are not covered by your contract or paid by your insurance carrier.

I am aware of the HIPPA privacy policy of the clinic and have been offered a personal copy.

I understand that I am ultimately responsible for all charges and fees that are incurred by me at this office for services and/or products, and I agree to pay any outstanding bills incurred in this office as well as paying for co-pay, co-insurance and/or deductible amounts as well as interest and attorney fees in the event of non-payment. I understand the requirements of the plans outlined above.

Signature _____ **Date** _____