Body Traxx Chiropractic
Confidential Patient Information

Name: _____ SS#_____-_____-_____

Age: ____ Birth Date: _____Cell: (____) ____-_____ E-mail:_____

Address _____City_____State_____Zip_____

□Male or □Female Marital: M S W D How many children? ____ Occupation _____

Closest Family Member (parent if minor) _____ Cell: (____) _____-_____

How did you hear about us? □ Google/Web □ Walk-In □ Friend: _____

Purpose of appointment (current problem) _____

Have you seen other doctors seen for this condition? □yes □no If yes who?_____

Is the condition due to injury or sickness arising out of an auto accident? □yes □no

Do you suffer from: (*Please check all that apply to you*)

□ Back Pain	□ Neck Pain	□ Shoulder/Arm Pain	□ Hip/Leg Pain
□ Headaches	□ Arthritis	□ Numbness	□ Nervousness
□ Cancer	□ Dizziness	□ Urinary Problems	□ Male/Female Troubles
□ Diabetes	□ Sinus Trouble	□ Digestive Disorders	□ Heart Trouble

Have you been treated for any health condition by a physician in the last year? □yes □no

If yes, Describe:_____

What medications are you taking? _____

What vitamins are you taking? _____

Females Only: Are you taking birth control pills? □no □yes Pregnant? □no □yes

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending Doctor of Chiropractic and it is the responsibility of the staff to carry out the instructions of such Doctor of Chiropractic (s).

Release of Information: By signing this form, you are granting consent to Body Traxx Chiropractic · Weight-Loss to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Signature (or Guardian Signature Authorizing Care) Date

Please fill out back side

Patient Name_____Date_____

1. What is your major symptom?_____
2. When was the first time you noticed this problem? _____

   How did it occur? _____

   Has it become worse recently? _____If yes, When and How? _____

   _____
3. How frequent is the condition? □Constant □Frequent □Occasional □Intermittent
4. Have you ever had the same or similar condition? □no □yes If yes, when and describe:

   _____
5. Describe type of Pain: □sharp □dull □throbbing □stabbing □aching □burning □tingling □shooting

   (Other)_____
6. Is there anything you can do which seems to provide relief? _____

   _____
7. What makes the problem worse? _____

   _____

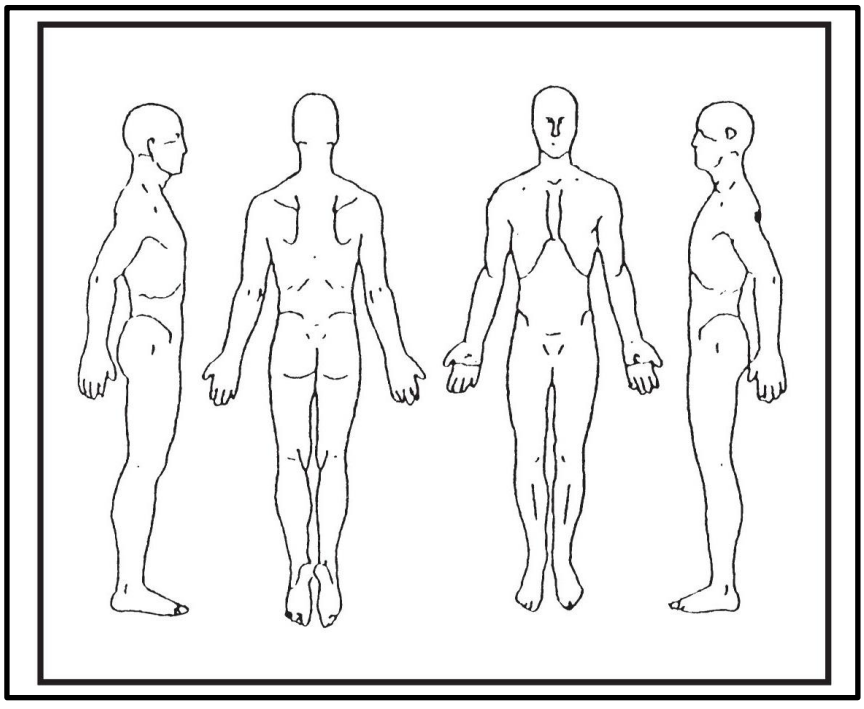
   _____
8. List accidents, illness, surgeries, or broken bones: _____

   _____

   _____

IMPORTANT!

9. Please Circle Your Symptom Areas



10. Rate the Severity of Your Condition