301 W. Atlantic Avenue, Suite O-6, Delray Beach, FL 33444, (561) 926-9494

My Bodyworx Inc. Health History Questionare

Child's Information

Child's Name _____ Birth Date ____/____/____

Parent's Name_____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Email Address _____

Would you like to receive our free monthly health and wellness newsletter via e-mail? Yes No

Has your child ever been to a chiropractor before? Yes No If yes, how long has it been?_____

Were you happy with their care? Yes No Explain_____

_____

Has your child ever been told they have any problems/defects in their spine or nerve system? Yes No

If yes, what? _____

Is your child here as a result of a motor vehicle accident? Yes No

Please list any traumas and approximately when they occurred (car accidents, falls, broken bones, etc.)

_____

_____

Whom may we thank for referring you to our office? _____

☐ Yellowpages ☐ Voice newspaper ☐ Website – which one? _____ ☐ Other _____

Let's Find Out Why You're Here…

What is the main reason for your child's visit today? _____
_____
_____

Any other specific reasons or concerns?_____
_____
_____

Were there any complications in the pregnancy or delivery of your child? Yes No
If yes, please explain_____
_____

Was your child born by C-Section? Yes No
How long was the actual labor and delivery time?_____
Did the doctor use forceps or other devices for delivery? Yes No
Did your child have early health challenges such as colic? Yes No
Did (or does) your child have frequent colds? Yes No
Did (or does) your child have ear infections? Yes No
Did your child have any falls or physical traumas that concerned you? Yes No
Please Explain_____
_____

Does your child have allergies, asthma or sinus problems? Yes No
Does your child have a problem bed-wetting? Yes No
Does your child have difficulty concentrating? Yes No
Do you feel your child has a weight problem? Yes No
Are there any other health problems that concern you? Yes No

_____
_____
_____

How would you describe the health of your child's eating habits on a scale of 1 to 10?

Very Poor 1 2 3 4 5 6 7 8 9 10 Perfectly Healthy

Are you satisfied with how healthy they eat? Yes No

How would you describe the amount of physical activity your child engages in on a scale of 1 to 10?

None 1 2 3 4 5 6 7 8 9 10 Very Active

Are you satisfied with their activity level? Yes No

Is there anything else you feel we should know?_____
_____
_____
_____

In compliance with federal requirements for the government electronic health records program, health care providers are required to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	**Dosage and Frequency *(i.e. 5mg once a day)***

Do you have any medication allergies?

Medication Name	**Reaction**	**Onset Date**	**Additional Comments**

❑ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____

Date:_____

Office Use Only

Height_____ Weight_____ Blood Pressure_____

Consent To Treat A Minor

I am the parent or legal guardian of _____

whose date of birth is _____ . I hereby authorize

(INSERT NAME OF PRACTICE) to administer chiropractic care for the treatment of conditions related to the spine. This includes but is not limited to physical examinations, x-rays, nutritional advice, and spinal adjustments.

Parent's Signature_____ Date:_____

Guardian's Signature_____ Date:_____

Witness_____
Date:_____

Assignment and Instruction for Direct Payment to Doctor

Private and Group Accident and Health Insurance

I hereby direct and instruct the _____ Insurance Company to pay by check made out and mailed directly to:

My Bodyworx Inc.
301 W. Atlantic Avenue, Suite O-6
Delray Beach, FL 33444

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO DOCTOR, THEN I HEREBY ALSO DIRECT AND INSTRUCT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

My Bodyworx Inc.
301 W. Atlantic Avenue, Suite O-6
Delray Beach, FL 33444

The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature of Policyholder_____
Date_____

Witness Signature_____ Date_____

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Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both of us to be working towards the same objective. Our only practice objective is to improve vertebral subluxation, a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to improve vertebral subluxations. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to express it's maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's improvement of vertebral subluxation. Our method of vertebral subluxation improvement is by specific chiropractic adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination or care, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease or disorder is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

All questions regarding the doctor's objective pertaining to care in this office have been answered to my satisfaction. I have read fully and understand the above statements and I accept chiropractic care on this basis.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF THIS OFFICE'S PRIVACY NOTICE

I acknowledge that I have received, and/or reviewed and that I also accept the terms of the following forms: Notice of Privacy Practices, Consent for use or Disclosure of Health Information, and Marketing Authorization. I am aware that I may receive a paper copy of this notice if I request it. In addition, I acknowledge that this notice of the office's Privacy Practices is posted where I can review it if desired.

_____ _____ _____

Patient Name Printed Patient Signature Date

_____ _____

Minor - Parent Signature of Patient under age of 18 Date

_____

Authorized Provider Representative (Office use only)

(561) 926-9494