



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

My Bodyworx Inc. Health History Questionnaire

Welcome! Thank you for choosing our practice for your health needs. Your first visit to our center is an opportunity for us to learn all about you. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Patient Information

Name _____

DOB ____/____/____ Age _____

Email _____

Phone:
Home _____

Cell _____

Preferred method of communication for appointment reminders (Circle one): Email / Text

If Text - Cell phone provider _____

Preferred Language: _____

Address _____

City _____

State _____ Zip _____

Married Widowed Divorced Single

Of kids _____ Ages: _____

Employer _____

Occupation _____

Whom may we thank for referring you to us?

Health History

Have you ever been to a chiropractor before?
 Yes No Last visit? _____

Good results? _____

Have you ever been told you have any problems/defects in your spine or nervous system?

Yes No Explain _____

Females - Pregnant? Yes No Due Date _____

Primary Care Physician _____

Primary Care Physician Phone _____

List any types of surgeries which you have had and the dates which they occurred:

List any traumas and the dates which they occurred (car accidents, fall, broken bones, etc.)

Daily Habits

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing

Light Labor Heavy Labor

Smoking: Yes No Former Packs/Day _____

Alcohol: Yes No Drinks/Week _____

Caffeine/Coffee: Yes No Cups/Day _____

High Stress Level: Yes No Reason _____

Patient Condition

Reason for Visit _____

If you have symptoms, when did they begin? _____

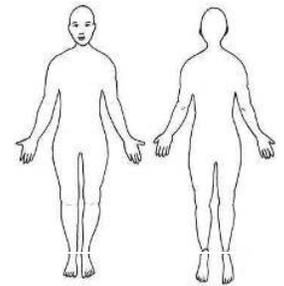
Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling

Rate the severity of your discomfort on a scale from 1 (least) to 10 (most) _____

Type of
discomfort:

- Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other _____



How often do you have this discomfort? _____

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

Activities or movements that are painful to perform:

- Sitting Standing Walking
 Bending Lying Down Other _____

What treatment have you already
received for your condition?

- Medications Surgery Physical Therapy
 Chiropractic None Other _____

Symptom's are your body's way of telling you something is wrong with your health. Please check off anything that you are **currently experiencing** or have experienced **more than once in the last 6 months**.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Neck Discomfort | <input type="checkbox"/> Low Back Discomfort | <input type="checkbox"/> Mid-back Discomfort |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Hand/Arm Numbness | <input type="checkbox"/> Leg/Foot Numbness |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fainting | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Nausea | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Colitis | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Shoulder Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Short breath |
| <input type="checkbox"/> Chest Congestion | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Blood Problems |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Infertility | <input type="checkbox"/> Extremity Weakness | <input type="checkbox"/> Extremity Swelling |

Please list any other health concerns not listed above _____

How committed are you to moving yourself toward greater levels of health and wellness?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

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>i.e. 5mg once a day</i>)

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 _____

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 Ave, Suite R-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 Ave, Suite R-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 _____

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

