

Boesky Chiropractic, PLC Confidential Health History

4204 S. Westnedge Ave. Kalamazoo, MI 49008 Ph (269) 342-9090 Fax (269)342-9054

Today's Date: ___/___/___ Legal Name: _____ Name to Call you: _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ Marital Status M S W D P

Cell Phone _____ Other Phone _____

e-mail address _____ (for private office use only)

Spouse/Partners Name _____ Number of Children under 18 _____

Would you share their names/ages with us? _____

Employer or School _____ Occupation or Major _____

How did you hear about our office? Another patient (please write their name here) _____

___ Sign ___ Our Website ___ Internet search ___ Doctor/Midwife _____ Other _____

Previous Chiropractor _____ Date of last adjustment _____

Are you currently pregnant? Y N Approximate Due date _____

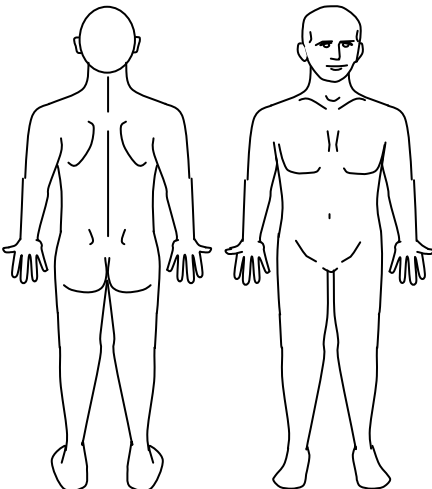
Previous Surgeries and dates _____

Previous auto accidents and dates _____

Current Medications _____

Height _____ Weight _____

Indicate symptoms on the figures: Darken in or circle



Check the Symptoms or Complaints you have had in the last year

Circle For Each Symptom You Have: 1= Very mild 10= Very Bad

Possible Neck Symptoms:

Neck Pain	1	2	3	4	5	6	7	8	9	10
Neck muscle pain/stiffness or spasm	1	2	3	4	5	6	7	8	9	10
Migraines with nausea	1	2	3	4	5	6	7	8	9	10
Migraines-no nausea Headaches	1	2	3	4	5	6	7	8	9	10
Arm pain Left Right	1	2	3	4	5	6	7	8	9	10
Arm/hand numbing	1	2	3	4	5	6	7	8	9	10
Shoulder pain	1	2	3	4	5	6	7	8	9	10
Dizziness	1	2	3	4	5	6	7	8	9	10
Jaw problems/TMJ	1	2	3	4	5	6	7	8	9	10
Ringing ears	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

Write here if needed:

Possible Upper/Mid-Back Symptoms:

Upper or Mid Back Pain	1	2	3	4	5	6	7	8	9	10
Upper/Mid back muscle or spasm	1	2	3	4	5	6	7	8	9	10
Chest pain	1	2	3	4	5	6	7	8	9	10
Rib pain	1	2	3	4	5	6	7	8	9	10
Digestive Problems	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

Write here if needed:

Possible Low Back/Hip/Sacroiliac Symptoms:

Lower Back Pain	1	2	3	4	5	6	7	8	9	10
Leg/Foot Numbing L R	1	2	3	4	5	6	7	8	9	10
Sciatic leg pain from back or hip L R	1	2	3	4	5	6	7	8	9	10
Low back muscle pain/stiffness or spasm	1	2	3	4	5	6	7	8	9	10
Sacroiliac or Hip Pain L R	1	2	3	4	5	6	7	8	9	10
Sciatic leg from back or hip L R	1	2	3	4	5	6	7	8	9	10
Tailbone Pain	1	2	3	4	5	6	7	8	9	10
Impotence	1	2	3	4	5	6	7	8	9	10
Menstrual problems	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

Write here if needed:

About Your Neck Symptoms:

What makes you Better?

What makes you Worse?

When did they Start? _____

Symptoms are:

___ Constant ___ Frequent ___ On/Off

Other information?

About your Upper/Mid Back Symptoms:

What makes you Better?

What makes you Worse?

When did they Start? _____

Symptoms are:

___ Constant ___ Frequent ___ On/Off

Other information?

About your Low Back/Hip Symptoms:

What makes you Better?

What makes you Worse?

When did they Start? _____

Symptoms are:

___ Constant ___ Frequent ___ On/Off

Other information?

ACTIVITIES DISCOMFORT SCALE

NAME: _____ DATE: _____

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Exercise					
8. Climbing Stairs					
9. Carrying					
10. Household Chores					
11. Driving					
12. Dressing					
13. Job Duties					

Are there any activities you are not able to do because of your current complaints? Please list them here

Fee Schedule:

Spinal Adjustments:

\$32 When purchased as a pre-pay package of 12 adjustments: \$384

Why purchase a pre-paid package?

Prepaid packages do not expire

Prepaid packages can be shared with others in your household

Unused visits are refundable.

\$42 When purchased individually

Exams & X-Rays:

Exams and X-rays on existing patients

\$30 Exam

\$30 for each X-Ray View

Payment terms and third party billing: Payment is due at time of service.

We do not bill to third parties such as insurance or Auto/Work companies.

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations

I acknowledge that Boesky Chiropractic, PLC "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Boesky Chiropractic, PLC Notice of Privacy Practices prior to signing this document. Boesky Chiropractic, PLC' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Boesky Chiropractic, PLC. The Notice of Privacy Practices for Boesky Chiropractic, PLC is also provided on request at the main administration desk of this practice and on Boesky Chiropractic, PLC" website at www.chiroandy.com. This Notice of Privacy Practices also describes my rights and Boesky Chiropractic, PLC' duties with respect to my protected health information.

Boesky Chiropractic, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Boesky Chiropractic, PLC website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing below you understand and agree to our financial and HIPPA policies:

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Relationship to Patient (Self, Parent, Guardian, etc)