BetterBody SOLUTIONS

Welcome to BetterBody Solutions

Please fill out our history forms *completely* and *accurately* to the best of your ability so that we can quickly get you on the road to health.

We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Date: _____ Social Security #_____

Name: _____
Last First M.I

Address_____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Cell Phone: _____ Home Phone: _____

Preferred method of communication: (Check one) Email___ Text___ + Carrier Name _____

Sex: _____Male _____ Female Age: _____ Birthdate: _____

___Married ____Separated ____Widowed ____Divorced ____Single ____Partnered for ___Yrs ____Minor

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

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

Patient Employer/School _____

Address: _____

Phone: _____ Occupation: _____

Spouse's Name: _____ SS#_____ - _____ - _____ Phone: _____

Birthdate: _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone_____

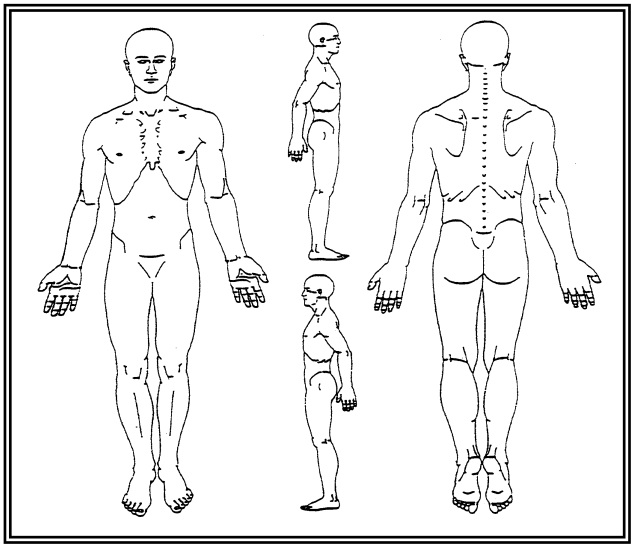
ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

BetterBody SOLUTIONS

Who is your Family Physician or Primary Doctor that monitors you? _____
Please indicate the main reason you are seeing us today: _____
_____

If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel in each location.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? _____ **Is there any numbness or tingling?** _____

How long have you been suffering with this problem, has it been more than a month or two? _____

When was the first time you EVER recall having a problem in this area? _____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? _____

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time) _____
Frequent (50 – 75% of the time) _____

Occasional (25 – 50% of the time) _____
Intermittent (0 – 25% of the time) _____

List any Doctors you've already seen for this problem: _____
_____

What have you tried or this problem? ☐Anti-inflammatory ☐Pain Meds ☐Muscle Relaxers ☐Injections ☐Physical Therapy ☐Chiropractic ☐Massage ☐Exercise ☐Other

What tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV ☐None ☐Other _____

What makes your problem <u>worse</u>? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting ☐Reaching ☐Driving ☐Sleeping ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit To Stand ☐Other_____

PAST MEDICAL HISTORY

Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

_____

Please list any surgeries you have had over the course of your life: _____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? ☐Yes ☐No **If yes, please list:** _____

List any medications, herbs or supplements you are taking and the reason for their use:

_____
_____

FAMILY HISTORY

Mother: ☐Living ☐Deceased List any medical problems: _____

Father: ☐Living ☐Deceased List any medical problems: _____

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis _____

SOCIAL HISTORY

Do you have any children? ☐Yes ☐No If yes, how many? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much & how often? _____

Do you smoke? ☐Every Day Smoker ☐Occasional Smoker ☐Former Smoker ☐Never Smoked

What do you do most of the day in your job postures, positions and repetitive movements: _____-

_____

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level_____ = _____

Place a Mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐Yes ☐No
Alcoholism ☐Yes ☐No
Allergy Shots ☐Yes ☐No
Anemia ☐Yes ☐No
Anorexia ☐Yes ☐No
Appendicitis ☐Yes ☐No
Arthritis ☐Yes ☐No
Asthma ☐Yes ☐No
Bleeding Disorders ☐Yes ☐No
Breast Lump ☐Yes ☐No
Bronchitis ☐Yes ☐No
Bulimia ☐Yes ☐No
Cancer ☐Yes ☐No
Cataracts ☐Yes ☐No
Chemical Dependency ☐Yes ☐No
Chicken Pox ☐Yes ☐No

Diabetes ☐Yes ☐No
Emphysema ☐Yes ☐No
Epilepsy ☐Yes ☐No
Fractures ☐Yes ☐No
Glaucoma ☐Yes ☐No
Goiter ☐Yes ☐No
Gonorrhea ☐Yes ☐No
Gout ☐Yes ☐No
Heart Disease ☐Yes ☐No
Hepatitis ☐Yes ☐No
Hernia ☐Yes ☐No
Herniated Disk ☐Yes ☐No
Herpes ☐Yes ☐No
High Blood Pressure ☐Yes ☐No
High Cholesterol ☐Yes ☐No
Kidney Disease ☐Yes ☐No

Liver Disease ☐Yes ☐No
Measles ☐Yes ☐No
Migraine's ☐Yes ☐No
Miscarriage ☐Yes ☐No
Mononucleosis ☐Yes ☐No
Multiple Sclerosis ☐Yes ☐No
Mumps ☐Yes ☐No
Osteoporosis ☐Yes ☐No
Pacemaker ☐Yes ☐No
Parkinson's Disease ☐Yes ☐No
Pinched Nerve ☐Yes ☐No
Pneumonia ☐Yes ☐No
Polio ☐Yes ☐No
Prostate Problem ☐Yes ☐No
Prosthesis ☐Yes ☐No
Psychiatric Care ☐Yes ☐No
Rheumatoid Arthritis ☐Yes ☐No

Rheumatic Fever ☐Yes ☐No
Scarlet Fever ☐Yes ☐No
Sexually Transmitted Disease ☐Yes ☐No
Stroke ☐Yes ☐No
Suicide Attempt ☐Yes ☐No
Thyroid Problem ☐Yes ☐No
Tonsillitis ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Tumors or Growths ☐Yes ☐No
Typhoid Fever ☐Yes ☐No
Ulcers ☐Yes ☐No
Vaginal Infection ☐Yes ☐No
Whooping Cough ☐Yes ☐No
Other:
_____
_____
_____
_____

Financial Responsibility

Patient Name_____

Dear Patient,
BetterBody Solutions provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.
I have read and understood all the above information.

BetterBody SOLUTIONS

_____ _____

Patient Signature Date

Insurance Information

Even if you are here through a non-referral source such as an external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID#_____

Subscriber Name _____ Birthdate: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Drs. Ryan Hasenclever and/or Eric Bailey, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of above signature Relationship to Patient

X-Ray Consent

I hereby give my consent to BetterBody Solutions and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.
I have read and understood all the above information.

_____ _____

Patient Signature Date

Clinical Summary (a required EMR question)

___ 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 Acknowledgement of Receipt of Notice of Privacy Practices

Print Patient Name: _____

I acknowledge that I have been provided a copy of the currently effective Notice of Privacy. A copy of this signed, dated document shall be as effective as the original.

DATE:_____

_____
Signature of Patient or Personal Representative

_____
Signature of Witness / Office Representative

You may refuse to sign the acknowledgement & authorization. In refusing, this practice will not be allowed to process your insurance claims. I acknowledge that I declined the Notice of Privacy Practices provided:

DATE:_____

_____
Signature of Patient or Personal Representative

_____
Signature of Witness / Office Representative
****

Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign ___ Communication barrier ___ Emergency situation occurred with patient ___ Other (explain):_____

Signature of Office Representative