



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: _____

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 _____

Occupation: _____

Spouse's Name: _____ Phone: _____

Emergency Contact (if not a spouse): _____ Relationship: _____
Phone _____

Who is your Family Physician or Primary Doctor that monitors you? _____

Please indicate the main reason you are seeing us today: _____

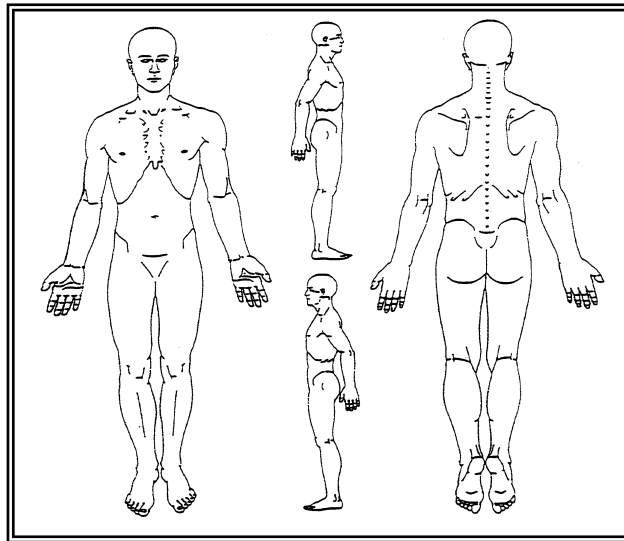


ACCIDENT INFORMATION: Is condition due to an accident? Yes ___ No ___ Date of Accident _____

Type of Accident: Auto ___ Work ___ Home ___ Other ___

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.

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 worse? 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: _____

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

- | | | | |
|--|--|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine's <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple | Transmitted |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide |
| Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's | Thyroid |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated | Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Problem <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or |
| Chemical | Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate | Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | High | Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Kidney | Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Care | Vaginal |
| | | Rheumatoid <input type="checkbox"/> Yes <input type="checkbox"/> No | Infection <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Arthritis | Whooping |
| | | | Cough <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Date: _____

Patient Signature

Insurance Information

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:

Subscriber Name _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to Dr. Ryan Hasenclever/BBS PPLC, 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.

_____ Date: _____
Patient Signature

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