# **Body Traxx** Chiropractic · Weight-Loss
## Confidential Patient Information

Name: ________________________________________________ SS#______-_____-_________

Age: ____ Birth Date: ____________Cell: (____) _____-________ E-mail:_________________________________

Address _______________________________________City_______________State______Zip___________

□Male or □Female  Marital: M S W D  How many children? ____  Occupation _______________________

Closest Family Member (parent if minor) ______________________________ Cell: (____) ______-__________

How did you hear about us?  □ Google/Web  □ Walk-In  □ Friend: ______________________________

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Purpose of appointment (current problem) _____________________________________________________

Other doctors seen for this condition__________________________________________________________

Is the condition due to injury or sickness arising out of an auto accident?  □yes  □no

Do you suffer from: (*Please check all that apply to you.*)

| | | | |
|---|---|---|---|
| □ Back Pain | □ Neck Pain | □ Shoulder/Arm Pain | □ Hip/Leg Pain |
| □ Headaches | □ Arthritis | □ Numbness | □ Nervousness |
| □ Cancer | □ Dizziness | □ Urinary Problems | □ Male/Female Troubles |
| □ Diabetes | □ Sinus Trouble | □ Digestive Disorders | □ Heart Trouble |

Have you been treated for any health condition by a physician in the last year?  □yes  □no

If yes, Describe:___________________________________________________________________________

What medications are you taking? ____________________________________________________________

What vitamins are you taking? _______________________________________________________________

**Females Only:** Are you taking birth control pills? □no □yes  Pregnant? □no □yes

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**Consent for Treatment**: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

**Release of Information:** By signing this form, you are granting consent to Body Traxx Chiropractic · Weight-Loss to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

______________________________________________________________________________________

Patient signature (or Guardian Signature Authorizing Care)  Date

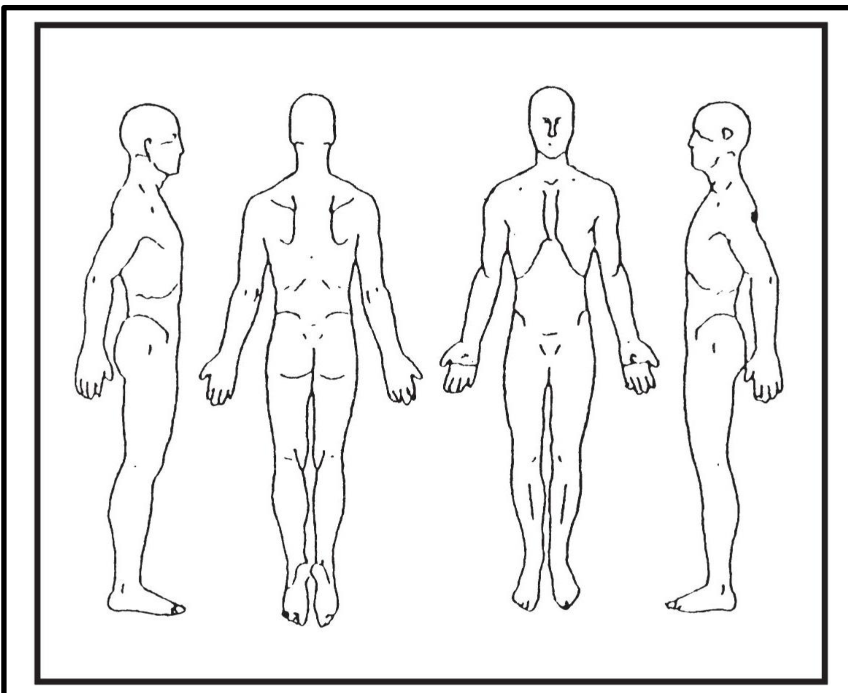
**Please fill out back side**

Patient Name______________________________________________________Date___________________

1. What is your major symptom?_______________________________________________________________
2. When was the first time you noticed this problem? _____________________________________________
   How did it occur? _________________________________________________________________________
   Has it become worse recently? _________If yes, When and How? _________________________________
   _______________________________________________________________________________________
3. How frequent is the condition? : □Constant □Frequent □Occasional □Intermittent
4. Have you ever had the same or similar condition? □no □yes If yes, when and describe:
   _______________________________________________________________________________________
5. If pain is involved is it: □sharp □dull □throbbing □stabbing □aching □burning □tingling □shooting?
   (Other)________________________________________________________________________________
6. Is there anything you can do which seems to provide relief? ______________________________________
   _______________________________________________________________________________________
7. What makes the problem worse? ___________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
8. List accidents, illness, surgeries, or broken bones: ______________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________

***IMPORTANT!***

9. Please Circle Your Symptom Areas



10. Rate the Severity of Your Condition