BodyEvolution

Quality. Life. Make the Adjustment.

3934 Murphy Canyon Road, Suite B104
San Diego, CA 92123
858-571-0160
www.BodyEvolution.org

Welcome to our office!

Please fill out this Health Record as completely and accurately as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with chiropractic care.

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About the Patient

Patient's Name:____

Address: ________________________________ City:_________________ State:_____ Zip:___________

Home Phone:_____________________ Cell Phone:_________________ Preference? ☐ Home ☐ Cell

Birthdate:____/____/______ Age: ______ Gender: ☐ Male ☐ Female How Many Children:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employer:______________________________ Work Address:___________________________________

Work Phone:________________________ Type of Work:____

Social Security #:_____-_____-_______ Email Address:_______________________________________

Payment Method: ☐ Cash ☐ Check ☐ Credit Card

Name on Card:_____________________ Credit Card#:______________________ Exp. Date:____/____

Reason for This Visit

Describe the purpose of this visit:

____

Is the purpose of this appointment related to:

☐ Job ☐ Sports ☐ Auto ☐ Fall ☐ Chronic Discomfort ☐ Home Injury ☐ Other
Please explain:____

If job related, have you made a report of your accident to your employer? ☐ Yes ☐ No

When did this condition begin:____

Has this condition: ☐ Gotten Worse ☐ Stayed Constant ☐ Comes and Goes

Does this condition interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities
Please explain: ____

Has this condition occurred before? ☐ Yes ☐ No
Please explain:____

Have you seen other doctors for this condition? ☐ Yes ☐ No
Dr.'s Name(s):____
Type of Treatment:____
Results:____

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Experience with Chiropractic

Who referred you to this office?____

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

Reason for those visits?____

Doctor Name(s):____

Approximate date of last visit?____

Has any other adult in your family had a Chiropractic adjustment? ☐ Yes ☐ No
Has any child in your family had a Chiropractic adjustment? ☐ Yes ☐ No

Were you aware that…

Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

The nervous system controls all bodily functions and systems? ☐ Yes ☐ No

Chiropractic is the largest natural healing profession in the world? ☐ Yes ☐ No

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ☐ Yes ☐ No

Goals for My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care: Symptomatic relief of pain or discomfort

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

☐ I want the Doctor to select the type of care appropriate for my condition.

______________________________ ______________________________
Patient's Signature Date

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Medications I Currently Take

☐ Nerve Pills
☐ Pain Killers (including asprin)
☐ Muscle Relaxers
☐ Blood Pressure Medicine
☐ Stimulants
☐ Tranquilizers
☐ Blood Thinners
☐ Insulin
☐Other:___________________
____
____
____

Health Habits

Do you smoke?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Do you drink coffee?	☐ Yes	☐ No

Do you exercise?
☐ Moderately
☐ Daily
☐ No

Do you wear:
☐ Heel Lifts
☐ Sole Lifts
☐ Inner Soles
☐ Arch Supports

For Women Only

Are you pregnant?	☐ Yes	☐ No
Are you taking birth control?	☐ Yes	☐ No
Do you have irregular cycles?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Do you experience painful periods?	☐ Yes	☐ No
Do you have breast implants?	☐ Yes	☐ No

Health Conditions

Please mark each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care:

☐ Severe or frequent headaches
☐ Sinus problems
☐ Dizziness
☐ Loss of sleep
☐ Pain between shoulders
☐ Frequent neck pain
☐ Numbness or pain in arms/legs/hands
☐ Lower back problems
☐ Digestive problems
☐ Ulcers/colitis
☐ Heart attack/stroke
☐ Thyroid problems
☐ Kidney problems
☐ Hepatitis
☐ Cancer
☐ Anemia
☐ Congenital heart defect
☐ Heart Surgery/Pacemaker
☐ High/low blood pressure
☐ Difficulty breathing
☐ Asthma
☐ Arthritis
☐ Alcohol/Drug abuse
☐ Venereal disease
☐ HIV/AIDS
☐ Diabetes
☐ Tuberculosis
☐ Shingles
☐ Chemotherapy
☐ Rheumatic fever
☐ Psychiatric problems
☐ Other:_________________________________

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Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine as she deems appropriate.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. I understand that if my insurance does not cover the full cost of the charges, I am responsible for payment of the difference.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

______________________________________ ______________________________________
Patient Signature Date Guardian or Spouse Signature Date

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Compensation
☐ Medicare ☐ Auto Insurance ☐ Personal Health Insurance

Emergency Contact Name:____

Relationship to You:____

Cell/Work Phone:_______________________________ Home Phone:____________________________

My Health Insurance

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the Doctor's office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt.

Name of Insured Person:____

Insurance Company:_____________________________ Policy #:_____________________________

Address:____ Group #:_____________________________

Phone #:____ Date of Birth:_________________________

Social Security # of Insured Person:____-____-______

Relation:____

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Office Fee Schedule and Financial Policy

Service	Fee
Comprehensive Consultation/Initial Examination	$55.00 - $120.00
Chiropractic Adjustments	$40.00 - 80.00
Doctor/Patient Conference	$50.00
Re-Examination	$55.00 - $75.00
Chiropractic EMG/Thermal Scan	$50.00
Family and Wellness Packages are available	Varies

Our experience has shown that it is wise to have an understanding with our clients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care at our office and you may choose the plan that you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well being and we will do our best to help you.

Important: All clients are responsible for full payment for the first visit unless other arrangements have been made in advance.

Today's payment will be made by: *(circle one)* Cash Check Credit Card

Cash: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. You agree to pay any outstanding balance within one month after termination of care.

Insurance: If you have insurance that covers chiropractic care, we will bill your insurance directly. On or before your second visit, please bring in your insurance card so we may make a copy of it. Until we have the completed necessary information to verify chiropractic coverage, you will be required to pay for your care. Most patients with insurance pay a nominal co-payment in addition to meeting their yearly deductible, if applicable. Most ordinary health policies are designed and intended to take care of acute problems only. When it is necessary for you to continue your care, on a maintenance program, our office will help design an affordable cash plan for you. If no coverage is available, or if the benefits become exhausted, then you will be personally responsible to pay for all charges incurred on a daily/weekly/monthly basis.

Auto Injury: You will need to supply us with your auto insurance information, liable parties' insurance, accident report and name of your attorney (if any). Once we are able to verify your automobile medical payment coverage, we will bill your insurance directly. If no coverage is available, or if the benefits become exhausted, then you will be personally responsible to pay for all charges incurred on a daily/weekly/monthly basis.

3rd Party Claim: When you make a claim against a 3rd party insurance policy, that policy does not reimburse the doctor directly for any services incurred as a result of the claim. You agree to be personally responsible to pay charges incurred on a daily/weekly/monthly basis (or at the time of settlement of your claim).

Attorney Lien: You agree to defer the balance of any unpaid charges until settlement of your claim/lawsuit. If you change attorneys or release your attorney prior to the settlement of your claim, this agreement is void and you agree to pay the full balance due immediately.

Agreement: My signature below signifies my agreement for payment in full on a cash basis if I have not provided Body Evolution with all necessary documents and information by the time of the second visit.

I have read and agree to the above statement:

____________________ ____________________

Patient's Name Patient's Signature

____________________ ____________________

Date Witness