BETTER HEALTH solutions

Date _____

WELCOME! In order to get started we need to obtain some information. A thorough understanding of your health history will help us to determine the most appropriate care. To speed up this process please allow our staff to photocopy your driver's license and all necessary insurance cards.

PATIENT INFORMATION (Please Print)

Full Name:_____DOB:_____ Sex: ❑ M ❑ F

SS#: _____-_____-_____ E-mail:_____

Street Address:_____

City: _____ State: _____ Zip: _____

Home Number:(____)_____-_____Cell Number: (____)_____-_____Work Number(____)_____-____

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

Employer Name & Phone Number: _____

Employer's Address: _____

Spouse's/Parent's Full Name: _____

Spouse's/Parent's Employer & Number: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Policy/ID #:_____ Group #: _____

Insured's Full Name & Phone #: _____

Insured's SS#: _____ Insured's DOB: _____

Insured's Relationship to you: _____

Secondary Insurance Company: _____

Policy/ID #:_____ Group #: _____

Insured's Full Name & Phone #: _____

Insured's SS#: _____ Insured's DOB: _____

Insured's Relationship to you: _____

MEDICAL HISTORY

Have you ever had Chiropractic care? ❑ Yes ❑ No

How did you find out about our office? _____

How long have you had the current problem? _____

Have you ever been treated for this problem before? ❑ Yes ❑ No
If yes, briefly explain: _____

PAST MEDICAL / SOCIAL / WORK HISTORY

(Check all that apply to you and/or your parents, siblings, or children)

❑Anemia	❑Muscular Dystrophy	❑Rheumatic Fever	❑Allergies	❑Cancer
❑Polio	❑Multiple Sclerosis	❑Scarlet Fever	❑HIV	❑Sinus Trouble
❑Asthma	❑German Measles	❑Nervousness	❑Numbness	❑Convulsions
❑Epilepsy	❑Concussion	❑Dizziness	❑Neuritis	❑Rheumatism
❑Diabetes	❑Arthritis	❑Venereal Disease	❑Backaches	❑Tuberculosis
❑Hepatitis	❑Kidney Disease	❑Thyroid Disease	❑Mental Illness	❑Liver Disease
❑Alcoholism	❑High Blood Pressure	❑Digestive Disorder	❑Heart Trouble	❑Stroke

Other: _____

Have you ever suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones?

❑ Yes ❑ No _____

_____

Do you work around hazardous materials? ❑ Yes ❑ No If yes, List: _____

Do you: *(Check all that apply)*

❑ Drink Regularly ❑ Smoke ❑ Take Recreational Drugs ❑ Eat a Poor Diet ❑ Exercise

ACCIDENT INJURY INFORMATION

Are your symptoms due to an accident? ❑ Yes ❑ No

If your answer is NO please go to the next section

Type of accident: ❑ Auto ❑ Work ❑ other: _____

Was the accident reported? ❑ Yes ❑ No; Date of Accident: _____

Type of claim: ❑ Worker's Compensation ❑ Auto Insurance ❑ Other: _____

Have you been treated for this condition? ❑ Yes ❑ No

If yes, list name & phone: _____

Company Name & Phone of your Auto Insurance: _____

Policy #: _____ Claim #: _____

Name of person at fault for the accident: _____

Person at fault's Insurance Company name & phone:_____

Have you ever been involved in a previous auto/work accident? ❑ Yes ❑ No

EMERGENCY INFORMATION

Family Doctor: _____ Office Number: _____

Emergency Contact: _____

Emergency Contact Number & Relationship to you: _____

Patient's Signature _____Date_____

Spouse's or Guardian's Signature _____Date_____

PROBLEM FOCUSED HISTORY

PLEASE DESCRIBE THE PROBLEM: _____

_____

_____

DETAILS OF CHIEF COMPLAINT:

1. **Does the Pain Stay in One Area or Does it Move to Other Areas?** ☐ No ☐ Yes
   a. The Pain… (❑ is Local ❑ is Diffuse ❑ Radiates to**:**_____**)**
2. **Onset: Did it Begin** ☐ Suddenly **or** ❑ Gradually **?**
   a. Date it began _____
   b. How did it happen? _____
   c. Was this the first episode or is this a chronic injury?
      ❑ Acute (0 to 72 hours) ❑ Subacute (72 hours to 6 weeks) ❑ Chronic (> 6 weeks)
   d. Is the pain worse in the morning or at night? ❑ AM ❑ PM ❑ Other:_____
3. **Type of Sensation:** How would you describe the pain?
   ❑ Sharp ❑ Shooting ❑ Severe ❑ Intolerable ❑ Dull ❑ Achy ❑ Throbbing ❑ Burning ❑ Stinging
   ❑ Deep ❑ Nagging ❑ Diffuse ❑ Numb ❑ Tingling ❑ Stiff ❑ Stabbing ❑ Cramping ❑ Other:_____
4. **Frequency** (How often do you notice the pain? Estimate the percentage of time.)
   ❑ Intermit. 0-25 ❑ Occas. 26-50 ❑ Frequent 51-75 ❑ Constant 76-100
5. **What Makes it Feel Worse?** ❑ Bending ❑ Twisting ❑ Lifting ❑ Walking ❑ Activity ❑ Other**:**_____
6. **Symptoms/Dysfunction Since Onset Have:**
   ❑ Decreased ❑ Increased ❑ Remained About the Same ❑ Been Erratic
8. **Have You Noticed a Change in Bodily Functions**: ❑ Yes ❑ No

❑ Balance	❑ Bowel Habits	❑ Breathing	❑ Coordination
❑ Coughing	❑ Gait	❑ Grip	❑ Hearing
❑ Menstrual	❑ Sexual	❑ Sleep	❑ Sneezing
❑ Urination	❑ Vision	❑ Weakness	❑ Weight

9. **Which is Your Dominate Hand:** ❑ L ❑ R ❑ Amb.
10. **Has Your Condition Affecting Your Daily Living in Any Way?** ❑ Yes ❑ No
    Describe activities and the effect: (Ex. sleep, housework, hobbies, etc.)_____
    _____
11. **Work Status: No. of Jobs** ❑ **1** ❑ **2** ❑ **3**
    I'm … ❑ Full Time ❑ Part-Time ❑ a student ❑ Retired ❑ Disabled ❑ Unemployed
12. **Are You on Work/Home Disability:** ❑ Yes ❑ No
    Complete: _____ Days off work
    _____ Days unable to perform household tasks
    Partial: _____ Days of job modification
    _____ Days of decreased household tasks
13. **Have You Used Any Store-bought or Home Remedies**: ❑ Yes ❑ No
    ❑ Ice ❑ Heat ❑ Massage ❑ Aspirin ❑ Other:_____
    Effect: _____

14. **Have You Seen Another Doctor For This Same or a Similar Problem?** ❑ Yes ❑ No
    Type of Dr., Tests, Dx, Tx, Effect:_____
    _____

15. **What Makes it Feel Better**?

❑ Lying Down ❑ Sitting ❑ Bending ❑ Rest ❑Other:_____

16. **Do You Have A Pacemaker or Any Other Surgically Implanted Device**? ❑ Yes ❑ No

Explain:_____

17. **(Females Only) -- Are You Now or Could You Be Pregnant**? ❑ Yes ❑ No

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I (we) hereby authorize **Dr. Abbas Khayami,** and whomever may be designated as assistants at Better Health Solutions to administer such examinations, treatments, testing and/or x-rays, as they deem necessary. I (we) understand that there is an inherent risk associated with all forms of treatment, including spinal adjustments and physiotherapy. I (we) agree to hold them free and harmless from any such claims, suits for damages, or complications, which may result from such treatments. I (we) agree that a photostatic copy of this agreement shall serve as the original.

I (we) agree that the aforementioned services are not complimentary and will be charged at the regular chiropractic rates of Better Health Solutions. I (we) agree to pay for services rendered to the aforementioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or noncovered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I (we) also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I (we) agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I (we) agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____

Spouse's or Guardian's Signature _____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

Patient Long – Term Signature Authorization

I hereby authorize the release of any medical or other information necessary, to *Better Health Solutions* in order to process my claim.

I also request payment of government benefits either to me or *Better Health Solutions*, who accepts assignment.

I also authorize payment of medical benefits to the above provider for any services.

This information also permits the release of information to this provider by HCFA, its intermediaries, or carriers on any unassigned Medicare claims.

I further permit copies of this authorization to be used in place of the original Term of Authorization.

Patient/Insured: (Please print and sign name):

Patient Signature

Patient Name (Printed)

Date