Boesky Chiropractic, PLC Confidential Health History

4204 S. Westnedge Ave. Kalamazoo, MI 49008 Ph (269) 342-9090 Fax (269)342-9054

Today's Date: _____ Legal Name: _____ Name to Call you: _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Birthdate _____ Age _____ Marital Status M S W D P SSN_____

Home Phone _____ Work Phone _____ Cell Phone _____

e-mail address _____ (for private office use only)

Preferred Method of Contact Home Phone Cell Phone Work Phone E-mail

Spouse/Partners Name _____Number of Children under 18 _____

Would you share their names/ages with us? _____

Employer or School _____ Occupation or Major _____

How did you hear about our office? Another patient (please write their name here)_____

___Sign ___Our Website ___Google search ____Doctor/Midwife _____ Other _____

Previous Chiropractor_____ Date of last adjustment _____

Are you currently pregnant? Y N Approximate Due date _____ Is the baby breech? Y N

Previous Surgeries and dates _____

Previous auto accidents and dates _____ _____

Current Medications _____ _____ _____ _____ _____

Allergies: List Here _____ _____ _____ _____ _____

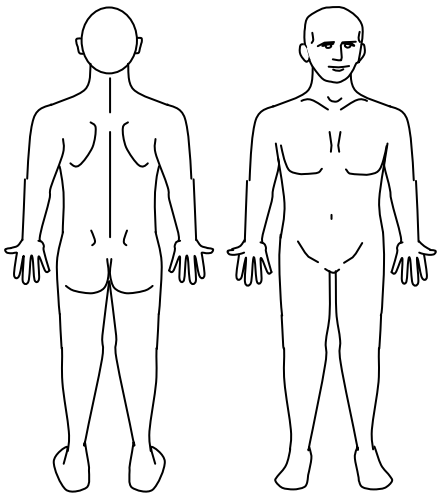
Do You Currently Smoke? Y N Have You Ever Smoked? Y N

Race/Ethnicity: ____ African-American ____ Caucasian ____ Asian ____ Latino-Hispanic

____Native American ____ Other_____

Preferred Language _____

Height _____ Weight _____



Indicate symptoms on the figures: Darken in or circle

Please check other health complaints you have or have had below

Circle C=Current I=Intermittent P=Past (over 1 year)

- ____**Neck pain** C I P _____
- ____**Upper Back Pain** C I P _____
- ____**Mid Back Pain** C I P _____
- ____**Lower Back Pain** C I P _____
- ____**Sacroiliac or Hip Pain** C I P _____
- ____**Tailbone Pain** C I P _____
- ____**Sciatica** C I P _____
- ____**Arm/Hand Numbing** C I P ___Left ___Right ___Both What area? _____
- ____**Leg/Foot Numbing** C I P ___Left ___Right ___Both What area? _____
- ____**Migraines with nausea** C I P How Often? ___Weekly ___Monthly ___Other_____
- ____Migraines-no nausea C I P _____
- ____Arm pain C I P ___Left ___Right ___Both _____
- ____Leg pain C I P ___Left ___Right ___Both _____
- ____Headaches C I P _____
- ____Muscle Spasms C I P ___Upper ___Mid Back ___Low Back _____
- ____Muscle Pain/stiffness C I P _____
- ____Dizziness C I P _____
- ____Irritability C I P _____
- ____Jaw problems/TMJ C I P _____
- ____Forgetfulness C I P _____
- ____Blurred vision C I P _____
- ____Fatigue C I P _____
- ____Ringing ears C I P _____
- ____Memory loss C I P _____
- ____Light sensitivity C I P _____
- ____Disturbed sleep C I P _____
- ____Muscle Pain (Mid-Upper) C I P _____
- ____Shoulder pain C I P _____
- ____Rib pain C I P _____
- ____Chest pain C I P _____
- ____Digestive Problems C I P _____
- ____Shortness of breath C I P _____
- ____Back stiffness C I P _____
- ____Impotence C I P _____
- ____Menstrual problems C I P _____

- Other symptoms not listed _____

_____

_____

Please Complete…Put ONLY ONE symptom or complaint in EACH BOX.

Name your worst symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? ______________________________________

What makes it Worse? ______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? ______________________________________

What makes it Worse? ______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? ______________________________________

What makes it Worse? ______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

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Does it radiate to other areas? Where? __________________________

What makes it Better? ______________________________________

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When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

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___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? ______________________________________

What makes it Worse? ______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

Name your next symptom here ________________________________

When did it begin? ______________ ___ It Began Suddenly ___Gradually ___ On/Off

What caused the symptom? ____

How bad is it? 0=None **0 1 2 3 4 5 6 7 8 9 10** 10=Worst

How does it feel? ___ Dull ___ Sharp ___ Shooting ___ Ache
___ Tingling ___ Numb ___ Other_______________

How often? ___ Constant ___ Intermittent ___Frequent ___ Occasional

Does it radiate to other areas? Where? __________________________

What makes it Better? ______________________________________

What makes it Worse? ______________________________________

When is it Better? ___ AM ___ PM ___ No special time
When is it Worse? ___ AM ___ PM ___ No special time

ACTIVITIES DISCOMFORT SCALE

NAME: _____ DATE: _____

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt	Hurts a Little	Hurts Very Much	Almost Unbearable	Unbearable
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Exercise					
8. Climbing Stairs					
9. Carrying					
10. Household Chores					
11. Driving					
12. Dressing					
13. Job Duties					

Are there any activites you are not able to do because of your current complains? Please list them here

_____

_____

_____

Boesky Chiropractic, PLC Informed Consent for Chiropractic Care

We encourage and support a shared decision making process between us regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

● Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

● Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal of chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays).

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.
In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. ANDREW BOESKY TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____ Date _____
Patient Signature

_____ Date _____
Boesky Chiropractic, PLC Signature

Parental Consent for Minor Patient:

I do hereby request and authorize the doctor to perform necessary services for the child named above, deemed advisable by the doctor. I certify that there are no court orders now in effect that prohibit me from signing this consent.

Patient Name:_____ Patient Age: _____ DOB: _____

Parent/Guardian Name _____Relationship to the minor: _____

Parent/Guardian Signature: _____

Boesky Chiropractic, PLC Signature _____

☐ I request that my child be able to maintain their chiropractic appointments without the presence of a parent/guardian when necessary. (This applies to children 14 years of age or older.)

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature Boesky Chiropractic, PLC Date

Insurance and Financial Agreement

If we can verify that you have coverage for care at this office, we will be glad to bill your insurance company for you. If your insurance company does not pay, or does not pay the full amount that we billed, you will be responsible to pay the balance upon receipt of insurance denial. *Please note verification of coverage does not guarantee payment by your insurance company. If there is a difference in the verified amount and the actual amount paid you will be responsible.

If you need to make special arrangements for payment, please let us know before you see the doctor today. Thank you!

First Health Insurance Company _____

Policy Number _____ Employer or Group # _____
If not your own name, whose name is the policy under? _____
What is this person's relationship to you? ____Spouse ____Parent
What is this person's date of birth? ____/____/_____

Second Health Insurance Company _____

Policy Number _____ Employer or Group # _____
If not your own name, whose name is the policy under? _____
What is this person's relationship to you? ____Spouse ____Parent
What is this person's date of birth? ____/____/_____

Please check one below:

☐ "I will pay cash for my care."
"I understand that payment is due at time of service unless other written arrangements are made in advance".

☐ "Bill my insurance for my care and I agree to pay what they reject"
"I understand that my insurance coverage is a contract between me and my insurance company. If my insurance does not pay, or does not pay in full, I agree to pay the balance due at the time of insurance denial."

Print your name here _____

Sign here _____ Date _____

Witnessed by Boesky Chiropractic _____

A note about your records at this office:
According to Michigan law, your health records, including all x-rays are the permanent property of our office. You are entitled to the information contained within your records but we cannot release your records directly to you. Copies of your x-rays can be made by us at a facility that performs this service, and given to you for a fee. If another physician requests your x-rays in writing from our office we will send them to that physician and they will be returned to us by that office. Thank you

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations

I acknowledge that **Boesky Chiropractic, PLC** "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review **Boesky Chiropractic, PLC** Notice of Privacy Practices prior to signing this document. **Boesky Chiropractic, PLC'** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Boesky Chiropractic, PLC**. The Notice of Privacy Practices for **Boesky Chiropractic, PLC** is also provided on request at the main administration desk of this practice and on **Boesky Chiropractic, PLC''** website at www.chiroandy.com. This Notice of Privacy Practices also describes my rights and **Boesky Chiropractic, PLC'** duties with respect to my protected health information.

Boesky Chiropractic, PLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing **Boesky Chiropractic, PLC** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Relationship to Patient (Self, Parent, Guardian, etc)