BODY ELEMENTS CHIROPRACTIC CLINIC
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WELCOME TO BODY ELEMENTS CHIROPRACTIC CLINIC

Please fill in the following information with as much detail as possible. Thank you!

Name					Date
Referred by			Email		
Cell Phone			Home Phone		
Address			City	State	Zip
Age	DOB	SS#	Married / Single / Other		
Names / Ages of Children					
Emergency Contact Name				Phone	
Your Occupation				Work Phone	

Primary Insurance		
Insurance Co. Name		Phone
Insurance Co. Address		
Insured Name	Insured Relationship to Patient	
Insured DOB	Insured ID/Claim #	Group #

Secondary Insurance		
Insurance Co. Name		Phone
Insurance Co. Address		
Insured Name	Insured Relationship to Patient	
Insured DOB	Insured ID/Claim #	Group #

LIFESTYLE QUESTIONS YOU MAY BE BRIEF; WE'LL GO INTO MORE DETAIL IF NECESSARY
Main purpose for consulting for care?
Is your symptom (s) related to an accident? Work Injury / Motor Vehicle Accident / Other Injury / NA
Is there currently a claim or lawsuit open or pending regarding this injury? Yes / No
If yes, please provide the name and phone number to your attorney:
Do you have any Mercury fillings? Yes / No
Do you have any root canals? Yes / No
Do/did you have any fractures? Yes / No If yes, how and where?
Do you have any scars? Yes / No If yes, where?
Were you on any medication for a prolong amount of time? Yes / No, If yes, for what and how long?
Are you taking any medication? Yes / No If yes, please list the name and purpose of each;
-Do you take Vitamin D? Yes /No - Probiotics? Yes / No -EFA? Yes / No -Multi Vitamin? Yes / No
Any other supplements? Yes / No If yes, please list the name and purpose of each;
Do you have any allergies? Yes / No If yes, to what?

LIFESTYLE QUESTIONS YOU MAY BE BRIEF; WE'LL GO INTO MORE DETAIL IF NECESSARY
Have you been hospitalized? Yes / No If yes, for what reason?
Have you had any surgery? Yes / No If yes, where on your body and why?
Any major accidents? Yes / No If yes, at what age?
What percent of your diet consists of fruits and vegetables? %
How many ounces of water do you consume on average, daily? Ounces
Are you vegetarian? Yes / No Do you consume dairy? Yes / No
How much protein do you consume? Never / Once in a while / Weekly / Daily / Multiple times per day
How much dairy do you consume? Never / Once in a while / Weekly / Daily / Multiple times per day
How much alcohol do you consume? Never / Once in a while / Weekly / Daily / Multiple times per day
Do you smoke? Never / Once in a while / Weekly / Daily / Multiple times per day
Do you exercise? Never / Once in a while / Weekly / Daily / Multiple times per day
Are you healthier now than you were 5 years ago? Yes / No
What do you prefer for your symptom(s)? Ice / Heat
When do you generally feel your best? A.M / Noon / P.M.
When do you generally feel your worst? A.M / Noon / P.M.
How committed to your health are you? Not 1 2 3 4 5 6 7 8 9 10 Extremely
How important is your health to you? Not 1 2 3 4 5 6 7 8 9 10 Extremely
Do you think your health is : Very Challenged / Challenged / Fair / Good / Excellent
Would you like your health to be: Very Challenged / Challenged / Fair / Good / Excellent

FEMALE ONLY! PLEASE
Are you currently pregnant? Yes / No If yes, how far along?
What method of birth control do you use? Abstinence / pill / IUD / Patch / Other:
Do you have any biological children? Yes / No If yes, what was the delivery method (i.e. C-section, ..)
Do you have episiotomy scars? Yes / No Have you had any miscarriages? Yes / No

CIRCLE P (PREVIOUSLY) OR C (CURRENTLY) IF APPLICABLE					
P	C	Headaches / Migraines	P	C	Nervousness
P	C	Insomnia	P	C	Chronic Tiredness
P	C	Dizziness / Light Headiness	P	C	Amnesia
P	C	Sinus Trouble	P	C	Allergies If so, where?
P	C	Earaches	P	C	Vision Problems and or Ear Problems
P	C	Stiff Neck	P	C	Acne / Pimples / Eczema / Psoriasis
P	C	Thyroid Condition / Throat Condition	P	C	Adrenal Condition
P	C	Excessive Sweatiness	P	C	Excessive Dryness
P	C	ADD / ADHD / OCD	P	C	Asthma
P	C	Difficulty Breathing / Lung Condition	P	C	Heart Condition / Palpitations / Surgeries
P	C	Nausea / Vomiting	P	C	Frequent Flu / Cough / Colds
P	C	STD's	P	C	Warts
P	C	Immune System Challenges	P	C	Jaundice
P	C	Gallbladder Condition / Removed / When?	P	C	Fevers
P	C	Liver Condition	P	C	Blood Pressure Challenges / High / Low
P	C	Poor Circulation / Arms / Hands / Legs / Feet	P	C	Diabetes / Type I / Type II / Insulin?
P	C	Slow to Heal from Cuts	P	C	Cancer

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CIRCLE P (PREVIOUSLY) OR C (CURRENTLY) IF APPLICABLE					
P	C	Arthritis	P	C	Indigestion
P	C	Heartburn	P	C	Ulcers
P	C	Kidney Challenges / Stones	P	C	Gas Challenges
P	C	Constipation	P	C	Diarrhea
P	C	Bladder Challenges	P	C	PMS – Emotional / Mood Swings
P	C	Impotency	P	C	Irregular Menstrual
P	C	Menstrual Cramps	P	C	Sciatica
P	C	Knee Pain	P	C	Swollen Ankles
P	C	Leg Cramps Daily / Weekly / Monthly	P	C	Weak Ankles
P	C	Hemorrhoids	P	C	TMJ issues
P	C	Grinding Teeth at Night	P	C	Shoulder Pain / Left / Right
P	C	Other:	P	C	Other:

CIRCLE M (MOTHER), F (FATHER) IF APPLICABLE AND IF APPLY TO YOUR FAMILY					
F	M	Diabetes	F	M	Heat disease
F	M	High Blood pressure	F	M	Chronic Tiredness
F	M	Lupus	F	M	Cancer
F	M	Other:	F	M	Other:

CHIEF COMPLAINT INFORMATION	
DESCRIBE YOUR PRIMARY CONCERN	**DESCRIBE YOUR SECONDARY CONCERN**
What?	What?
How did it start and when?	How did it start and when?
Have you experienced this before?	Have you experienced this before?
What does it feel like? Deep / Dull / Achy / Sharp	What does it feel like? Deep / Dull / Achy / Sharp
What makes it worse?	What makes it worse?
What makes it better?	What makes it better?
How often? Daily / Weekly / Monthly	How often? Daily / Weekly / Monthly
Is it constant? Yes /No	Is it constant? Yes / No
How severe? 1 (low) – 10 (high)	How severe? 1 (low) – 10 (high)
What all have you tried to do to resolve it?	What all have you tried to do to resolve it?

PLEASE EITHER USE A NUMBER TO RATE HOW YOU PERCEIVE YOUR LIFE EXPERIENCES. 1 (POOR) – 10 (EXCELLENT) OR ANSWER YES OR NO	
	Do you have confidence and a compassionate view of yourself?
	Are you open to new ideas?
	Do you like what you do for a living?
	Do you enjoy a sense of purpose and peace in your life?
	Are addictions a challenge for you?
	Are you teachable? Do you invite constant and never ending improvement in your life?
	Do you sleep well at night and awake rested?
	Do you awake frequently at night to urinate? If yes, how many times on average?
	Do you have a sustained energy throughout the day?
	What emotion(s) best describes you?

Is there anything else you would like us to comment on today?

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Almost done! Lastly, we want to be absolutely certain that agreements are in place in order to avoid any disagreements…

TERMS OF ACCEPTANCE
I understand and agree that Doctor Zaré has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Please Initial _____ Patient / Legal Guardian

ASSIGNMENT, AUTHORIZATION
I hereby consent to a chiropractic evaluation and examination, sEMG, Thermography, PWP (Heart Rate Variability) scan, chiropractic treatment(s), supplements, healthy lifestyle information (books, CD's, DVD's etc), activities of daily living information or laboratory procedures rendered to the client which Dr. Zaré may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Body Elements Chiropractic. I hereby authorize Dr. Zaré to release information requested on this form and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment.

Please Initial _____ Patient / Legal Guardian

FEDERAL HIPAA PRIVACY RULE CONSENT FORM
By signing this form, you are giving Dr. Zaré permission to use and disclose your protected health information for the purposes of treatment, payment, and healthcare operations. A copy of our Notice of Privacy Practices may be obtained from the internet or website. Please note, however, that our Notice of Privacy Practice may be changed as needed to comply with Federal Law.

Please Initial _____ Patient / Legal Guardian

PHILOSOPHICAL AGREEMENT
I hereby agree and understand that health is a state of optimal physical, mental and social wellbeing, not merely the absence of disease. I understand that Dr. Zaré does not offer diagnosis or treatment for specific diseases. Dr. Zaré's practice objective is to eliminate interference to the expression of the body's innate wisdom and to create an alkaline environment that supports my body to integrate, update and hold your adjustments.

Please Initial _____ Patient / Legal Guardian

TERMS AND FINANCIAL RESPONSIBILITY
I claim full financial responsibility for services rendered with Body Elements Chiropractic and Dr. Zaré will not be responsible for filing of claim responsible for payments of my account. I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization collection my insurance claim of benefits or negotiation a settlement with my insurance company. I know I am responsible for payment of my account and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance will not accept the responsibility for filing of collection company are pre-authorized and that any balances for denied services, deductibles, coinsurances and co-pays are my responsibility to pay.

Upon request, a super bill with all diagnosis and procedural information will be provided for you to submit to your insurance for possible reimbursements. Visa/MC and Discover are accepted. Please make checks to Body Elements Chiropractic Clinic. Return check free is $30.

Please be courteous of our time as we are with yours. A 24 hour cancellation notice is appreciated and in the case of repeated no-show incidents, we reserve the right to charge a fee of $50 for the missed appointment.

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1 ½ per month (annual percent rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

Please Initial _____ Patient / Legal Guardian

I have read the above statements and understand Body Elements Chiropractic's objectives pertaining to my care in this office.
Signature ____ Date _______________

Your health is your greatest asset. Thanks for the opportunity to serve you!

OFFICE USE ONLY
PT: ☐DR ☐EX ☐AM ☐AN VO:☐ TPR ☐CC ☐WC G/WF:

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