



5072 W. Plano Pkwy Plano, TX 75093 972-200-5009

Welcome to our office! PLEASE PRINT AND COMPLETE ALL SECTIONS

Appointment Date: _____ Referred By: _____
 Name (first, middle, last) _____ Preferred Name: _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Work (____) _____ Cell (____) _____
 Social Security # _____ Date of Birth ____/____/____ Age _____ Male Female
 Occupation _____ Employer _____
 Marital Status: M S W D Name of Spouse: _____
 Names and Ages of children _____
 Nearest Relative Not Living With You: _____ Phone: (____) _____
 Nearest Friend Not Living With You: _____ Phone (____) _____
 Email: _____

TELL US ABOUT ALL PRESENT AND PAST CONDITIONS:

Please mark, in front of each statement **ANY** that apply to you. Place and **“X”** for any **present conditions** and, **“O”** for any **past conditions** that are no longer an issue. **If it does not apply to you, please leave it blank.**

Extremities	Respiratory	Other Conditions	Male
___ Hip Pain or Stiffness R/L	___ Asthma	___ Headaches/Migraines	___ Impotence
___ Foot Pain Stiffness R/L	___ Chest Pain	___ Trouble Sleeping	___ Prostrate Problems
___ Wrist Pain or Stiffness R/L	___ Difficulty Breathing	___ Excessive Sweating	Female
___ Elbow Pain or Stiffness R/L	___ Lung Problems	___ Cancer Type: _____	___ Menopausal Problems
___ Shoulder Pain or Stiffness R/L	Digestion	___ Emotional/Mental Disorders	___ Menstrual Cycle Problems
___ Swollen or Painful Joints	___ Heartburn	___ Learning Disability	Urinary Tract
___ Jaw Pain or Clicking or Popping R/L	___ Digestion Problems	___ Nervous/Irritable	___ Kidney Trouble
___ Knee Pain or Stiffness R/L	___ Gallbladder Problems	___ Loss of Memory	___ Frequent Urination
Spine	___ Colon Trouble	___ Dizziness/Loss of Balance	___ Bedwetting
___ Head/Shoulders Feel Heavy/Tired	___ Diarrhea/Constipation	___ Arthritis	___ Other:
___ Neck Pain or Stiffness R/L	___ Hemorrhoids	___ Epilepsy/Convulsions	Organ Problems/Dysfunction
___ Upper Back Pain or Stiffness R/L	Immune	___ Knocked Unconscious	___ Diabetes
___ Mid Back Pain or Stiffness R/L	___ Skin Problems	___ Frequent Ear Infections	___ Liver Trouble
___ Low Back Pain or Stiffness R/L	___ Sinus / Allergies	___ Ringing in Ear R/L	___ Hepatitis
___ Pain with cough/sneeze or strain	___ Frequent Colds/Flu	___ Hearing Loss R/L	___ High/Low Blood Pressure
___ Difficulty with (circle all that apply) Standing/Walking/Sitting/Bending/Lifting/Twisting	___ Anemia	___ Trouble Concentrating	___ Heart
Numbness/Tingling or Pain in:	___ Other:	___ AIDS/HIV	
___ Arms/ Hand/Fingers R/L		___ Fracture/Dislocation of Bones: _____	
___ Legs / Feet / Toes R/L		___ Other:	

Patient Name: _____

Date: _____

TELL US ABOUT YOUR PRESENT AND PAST HEALTH CONDITION(S)

1. Primary Complaint(s): _____ How long have you suffered with this? _____
2. Secondary Complaint(s): _____ How long have you suffered with this? _____
3. Tertiary Complaint(s): _____ How long have you suffered with this? _____

2. What have you tried to do to get rid of this problem that DID NOT work? _____

3. Have you become discouraged about handling this problem? Yes No

4. When your problem is at its worst, how does it make you feel? _____

5. Does this problem interfere with the following areas of your life?

Family: Yes No If yes, please explain: _____

Work: Yes No If yes, please explain: _____

Hobbies: Yes No If yes, please explain: _____

Life: Yes No If yes, please explain: _____

6. Does handling this problem cause stress for you? Yes No

7. What activities make this problem worse? _____

8. How much older does this problem make you feel: _____

9. What gives you some temporary relief? _____

10. What is the pattern of this problem? (circle one) Constant, Intermittent, Occasional, Cyclic

11. What effect does this problem have on your body functions? _____

12. Is your condition due to : work condition auto accident other _____

13. If accident related give date and description of accident: _____

14. Name other type of doctor you have seen for this condition: what was done and for how long?

15. On a scale of 1 to 10, with 10 being the most, rate your commitment level in helping us solve this problem:

16. Tell us about your past medical history: What? When? Results?

Surgeries: _____

Hospitalizations: _____

Major Illness: _____

17. List any medications you take (prescription & non-prescription) and why you take them:

18. Are you currently taking anti-coagulant medication/therapy? Yes No

19. Do you have any other problems/complaints? Yes No If yes, please explain:

20. Is there any other information you would like us to know? Yes No If yes, please explain:

21. Do you have any children? Yes No

Do they have any health problems that you are aware of or that concern you? Yes No

22. When did you last see a chiropractor? _____ Dr. Name: _____

For what reason? _____

What spinal maintenance programs were you given to maximize the stability of your spine?

Did you follow the Doctor's recommendations? Y N If no, Why not? _____

Why are you changing chiropractors? _____

Patient Name: _____ Date: _____

TELL US ABOUT YOUR HEALTH GOALS

1. What are your health goals? _____
2. How do you expect to achieve these goals? _____
3. What are your expectations of this office? _____
4. How do you want us to handle your problem?
___ Temporary Relief (help the symptom, but do not fix the cause of the problem)
___ Maximum Correction (correct the cause of the problem for maximum stability in the future)
5. On a scale of 1-10 (10 being the **MOST**, and 1 being the **LEAST**):
___ How committed are you to being at your maximum health potential?
___ How important is it for your family to be at their optimum health potential?
___ How committed are you to preventing arthritis and maximizing your spinal stability?
6. What are your favorite hobbies or activities? _____

7. What activities are you looking forward to doing in retirement?

I verify that all of my information is correct and that I have completed all questions with as much information as is possible.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____



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Name: _____ Date: _____

Please Check What You Have Difficulty in Doing Because Of Pain:

	No Difficulty	Semi- Difficulty	Moderate Difficulty	Severe Difficulty
Cooking				
Gardening				
Running				
Playing Sports				
Swimming				
Caring for kids/grandkids				
Sleeping				
Housework				
Car Riding				
Vacationing				
Working (Job)				
Turning to Blind Spot				
Bathing				
Dressing				
Extended Sitting Hours				
Reading				
Computer Work				
Eating				
Walking				
Exercising				
Using Hand Tools				
Walking Up & Down Stairs				
Getting In/Out Car				
Manual Shifting Car				
Taking Care of Family				
Painting				
Pulling Luggage				
Lawn Care				

Other Notes:



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RELEASE AND CONSENTS

AUTHORIZATION FOR DIAGNOSIS AND TREATMENT

I authorize Drs. Steven and Laura Le, DC and whomever they may designate as their assistants to administer diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

Signature of Responsible Person: _____

Relationship of responsible person: _____

CONSENT TO X-RAY EXAMINATIONS

If and when deemed necessary, I do hereby consent to x-ray examination.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.
Last Menstrual Period Date _____

Signature of Responsible Person: _____ Date: _____

AUTHORIZATION TO TREAT A MINOR CHILD

I hereby authorize Drs. Steven and Laura Le, licensed Doctors of Chiropractic in the state of Texas, to administer treatment as deemed necessary to my Son/Daughter/Other: _____

Child's Name: _____

Signature of Guardian: _____ Date: _____

Worker's Compensation and Personal Injury:

INSURANCE ASSIGNMENT OF BENEFITS

I hereby instruct and direct my personal injury protection carrier and/or my auto insurance carrier and any liability carriers of any and all person(s) at fault of my injuries, and my attorney to DIRECTLY pay in full to Best Life Chiropractic and Wellness Center, LLC under current insurance policy as payment towards the total charges for the services rendered to me. This is a direct assignment of my rights and benefits under my policy. I further direct my personal injury protection carrier and all other insurance companies involved, to pay Stone Best Life Chiropractic and Wellness Center, LLC directly, overriding any and all powers of attorney which may have been or may be submitted by my attorney. A photocopy of this assignment shall be considered as claims paid, to my insurance companies and/or my attorney.

I have read, understand, and agree to this information:

Signature of Responsible Person: _____ Date: _____

Witness: _____

Detailed Information - Primary Complaint

1. What is your **PRIMARY** complaint? _____
2. How long have you suffered with this? _____
3. How did your primary complaint start? _____
4. Please circle or describe what your primary complaint feels like:

Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
Other: _____

5. How often does your complaint occur?

Constant

Intermittent

Occasional

6. How would you rank your primary complaint on a pain scale from 1 to 10; 10 being the most painful: ____
7. Does your complaint ever radiate to any other areas? Yes No If yes, please describe: _____

8. Currently, what makes it better? _____

9. Currently, what makes it worse? _____

10. If applicable, in the past when you were suffering with your primary complaint, please circle or describe what your complaint felt like:

Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
Other: _____

11. How often did your primary complaint occur in the past?

Constant

Intermittent

Occasional

12. Since it began, your primary complaint has: (please circle)

Worsened

Improved

Stayed the Same

13. In the past, what made it better? _____

14. In the past, what made it worse? _____

15. Please check all that you have done so far to help with your primary complaint:

Medicine Physical Therapy Exercise Rest Ice Heat

Massage Herbal Remedy Chiropractic Adjustments Yoga Surgery

Psychiatrist/Psychologist/Counseling Nothing

16. What medication(s), if any, are you taking for your primary complaint? _____

17. If you have had surgery regarding this complaint, please describe it: _____

Signature

Date

Detailed Information - Secondary Complaint

1. What is your **SECONDARY** complaint? _____
2. How long have you suffered with this? _____
3. How did your secondary complaint start? _____
4. Please circle or describe what your secondary complaint feels like:

Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
Other: _____

5. How often does your complaint occur?

Constant

Intermittent

Occasional

6. How would you rank this complaint on a pain scale from 1 to 10; 10 being the most painful? _____
7. Does your complaint ever radiate to any other areas? Yes No If yes, please describe: _____

8. Currently, what makes it better? _____
9. Currently, what makes it worse? _____
10. If you've suffered from this complaint in the past, please circle or describe what it felt like:

Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
Other: _____

11. How often did your secondary complaint occur in the past?

Constant

Intermittent

Occasional

12. Since it began, your secondary complaint has: (please circle)

Worsened

Improved

Stayed the Same

13. In the past, what made it better? _____
14. In the past, what made it worse? _____
15. Please check all that you have done so far to help with your secondary complaint:

Medicine Physical Therapy Exercise Rest Ice Heat

Massage Herbal Remedy Chiropractic Adjustments Yoga Surgery

Psychiatrist/Psychologist/Counseling Nothing

16. What medication(s), if any, are you taking for your secondary complaint? _____
17. If you have had surgery regarding this complaint, please describe here: _____

Signature

Date

Detailed Information - Tertiary Complaint

1. What is your **TERTIARY** complaint? _____
2. How long have you suffered with this? _____
3. How did your tertiary complaint start? _____
4. Please circle or describe what your tertiary complaint feels like:

Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
Other: _____

5. How often does your complaint occur?

Constant

Intermittent

Occasional

6. How would you rank this complaint on a pain scale from 1 to 10; 10 being the most painful? _____
7. Does your complaint ever radiate to any other areas? Yes No If yes, please describe: _____

8. Currently, what makes it better? _____
9. Currently, what makes it worse? _____
10. If you've suffered from this complaint in the past, please circle or describe what it felt like:

Aching Tight Burning Sharp Numbing Tingling Dull Weak Shooting
Other: _____

11. How often did your tertiary complaint occur in the past?

Constant

Intermittent

Occasional

12. Since it began, your tertiary complaint has: (please circle)

Worsened

Improved

Stayed the Same

13. In the past, what made it better? _____
14. In the past, what made it worse? _____
15. Please check all that you have done so far to help with your tertiary complaint:

Medicine Physical Therapy Exercise Rest Ice Heat

Massage Herbal Remedy Chiropractic Adjustments Yoga Surgery

Psychiatrist/Psychologist/Counseling Nothing

16. What medication(s), if any, are you taking for your tertiary complaint? _____
17. If you have had surgery regarding this complaint, please describe here: _____

Signature

Date

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Best Life Chiropractic and Wellness Center is committed to protecting your personal health information. Personal health information may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your health information is required by law. It tells you about your rights and how we use and disclose your health information.

YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your health information; however, we are not required to approve your request.
- Request that we notify you about your health information in a way or at a location that will help you keep your information confidential.
- Receive a list of disclosures we have made of your health information.
- In writing at any time, withdraw your permission for us to disclose your health information, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own health information.
- Ask us to change your health information if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

HOW BEST LIFE CHIROPRACTIC AND WELLNESS CENTER MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provided to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

REQUIREMENTS BY LAW: We may use and disclose your health information when required to do so by law.

- To reply to proper requests for your health information from a court or other legal agency.
- To report information for public health, such as reporting victims of abuse, neglect or domestic violence or reporting to the Food and Drug Administration problems with products or reactions to medications.
- To report information for public safety, such as to prevent the spread of a serious threat to the health and safety of a particular person or the general public.
- To assist law enforcement officials, such as the police, in their law enforcement duties.
- To allow funeral directors, medical examiners, or coroners to carry out their lawful duties, such as to complete a death certificate for the state.
- To comply with laws and regulations related to Worker's Compensation.
- To allow other government agencies to provide you with benefits and services.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your health information to government health agencies for health oversight reasons, such as program audits or licensure reviews.

RESEARCH: We may use your health information for approved research purposes, such as for study to cure a disease.

SPECIAL GOVERNMENT FUNCTIONS: We may such as protection of public officials or reporting to various branches of the armed services, may require the use or disclosure of your health information.

OBLIGATIONS OF BEST LIFE CHIROPRACTIC AND WELLNESS

- Maintain the privacy of your protected health information.
- Provide you with the Notice of its legal duties and privacy practices with respect to your health information.
- Obtain your written authorization to use or disclose your health information for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your information is used or disclosed.
- Allow reasonable requests you may make to notify you about your health information in a way or at a location that will help you keep your health information confidential.

Best Life Chiropractic and Wellness reserves the right to change its information practices. The new provisions will be effective for all protected health information that Best Life Chiropractic and Wellness Center maintains. Revised notices will be made available to you by written notices and on the Best Life Chiropractic and Wellness website at: www.bestlifechiro.com

COMPLAINTS:

If you have a complaint about how Best Life Chiropractic and Wellness handles your health information, or if you otherwise believe that your privacy rights have been violated by Best Life Chiropractic and Wellness, your complaint should be directed to:

Best Life Chiropractic and Wellness Center, 5072 W. Plano Parkway, Suite 130, Plano, Texas 75093 (972) 200-5009

Attention: Privacy Contact

If you are not satisfied with the manner in which Best Life Chiropractic and Wellness handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Best Life Chiropractic and Wellness if you file a complaint.