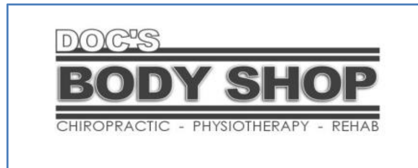
Doc's Body Shop Chiropractic
3084 N. Goliad St., Ste. 114
Rockwall, TX 75087
(972) 722-2500
FrontDesk@DocsBodyShop.com



PATIENT INFORMATION QUESTIONNAIRE

Name: ____

Address: ____

City, State, Zip: ____

Home/Cell Phone: _________________________

E-Mail: __________________________________

Date of Birth: ______ / ______ /______

Sex: □ Male □ Female

Driver's License #: (state) ___ (#) ______________

Social Security #: __________________

Check One: □ Married □ Single □ Divorced □ Widowed

Employer: ________________________________

Occupation: ______________________________

Work Phone: ______________________________

Emergency Contact:
Name: _________________________ Phone Number: _____________ Relation to patient: _________

Insurance Information:
Will you be using insurance benefits? □ Yes □ No

Insurance Carrier: ____

Patient ID and Group number: ___________________________________

If the policy is not in your name, please provide the following information for the primary policy holder:

Policy Holder's Name: __________________________Policy Holder's Date of Birth: _______________

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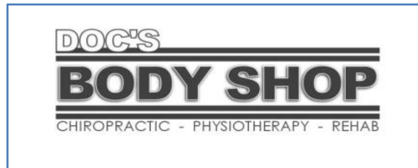

PATIENT CONSENT TO CARE

I, ________________________________, hereby authorize Doc's Body Shop Chiropractic and/or its representatives to render routine health care to myself or my child.

A patient coming to Doc's Body Shop Chiropractic gives the office permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

________________________________ ____________
Patient Signature Date

________________________________ ____________
Office Staff Date

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, ________________________________, acknowledge that I have received a copy of Doc's Body Shop Chiropractic's "Notice of Privacy Practices" and consent to the use and disclosure of my personal health information by for treatment, billing/payment, and healthcare operations as outlined in the "Notice of Privacy Practices".

I have read and understand the foregoing.

________________________________ ____________
Patient's Signature Date

________________________________ ____________
Office Staff Date

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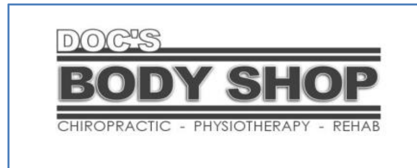

FINANCIAL AGREEMENT

Doc's Body Shop Chiropractic wants your care to be our primary focus. The following information should be used as a guide for how payment is collected here at the Shop. If you have any questions please do not hesitate to ask Caitlin or Dr. Woodward. We will help you meet your goals so you can *Get Better Here!*

Method of Payment

- Cash patients are required to pay at the time of service. Prepayment plans are available.
- If you are using private insurance all copays or coinsurance are due at time of service. If you have a Healthcare/Flexible Spending Account please provide that information to Caitlin.
- If you are using an auto insurance carrier for coverage no payment is due. Doc's Body Shop will work directly with any auto insurance carrier for payment restitution. No action is required on your part.
- There will be a 1.5% finance charge on all balances after 60 days.
- There will be a $30 charge on all returned checks.
- If you need records of financial transactions please see Caitlin. We will provide that to you at no additional charge.

Insurance Coverage

- Doc's Body Shop charges fees that are fair and reasonable by most insurance carriers. If your particular carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card on file.

By signing below, I acknowledge that I have read the Financial Agreement.

Patient Name (Printed): ____

__________________________________ ____________
Patient's Signature Date

__________________________________ ____________
Office Staff Date

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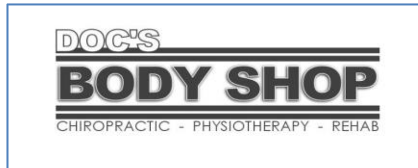

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: _______________

Is this condition: □ Job Related □ Auto Accident □ Sports Injury □ Chronic □ Other: ____________

Has this Condition occurred before? □ No □ Yes, when? _____________________________

Please circle the location(s) of your problem(s):

Headaches	Shoulder	Hand	Legs
Jaw	Arm	Mid back	Knee
Neck	Elbow	Low back	Ankle
Upper back	Wrist	Hip	Foot

Other: ____

How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

How would you describe the type of pain?
□ Sharp □ Numb □ Dull □ Tingly
□ Diffuse □ Sharp with motion □ Achy □ Shooting with motion
□ Burning □ Stabbing with motion □ Shooting □ Electric like with motion
□ Stiff □ Other: ___________________

How are your symptoms changing with time?
□ Getting Worse □ Staying the Same □ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____________
□ Massage Therapist □ Physical Therapist □ No one

How long have you had this problem? ____
When did the problem begin? ____
How did the problem begin? ____
Do you consider this problem to be severe? □ Yes □ Yes, at times □ No
What treatments or activities makes it better? ____
What treatments or activities makes it worse? ____
What concerns you the most about your problem; what does it prevent you from doing?
____

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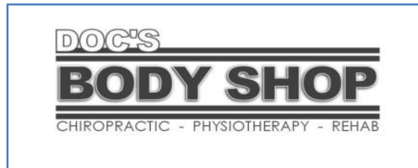

What is your height? ______ ft. ______ in.
How much do you weight? ______ lbs.
Date of Birth? ______ / ______ /______
Occupation? ______________________

Job Type:
□ Trader □ Professional/Executive □ White Collar □ Tradesperson □ Laborer □ Disabled
□ Homemaker □ Truck driver □ Student □ Retired □ Unemployed □ Other________

In general, how do you rate your overall health? □ Excellent □Very Good □Good □ Fair □Poor

What kind of exercise do you perform? □Strenuous □ Moderate □Light □None

Do you have an immediate family member with any of the following?
□ Rheumatoid arthritis □ Heart problems □ Diabetes □ Cancer
□ Lupus □ ALS □ Other: ______________

Please check all that apply to you in the appropriate column:

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:______________________________				

Please list all prescription medications you are currently taking:
____
Please list all supplements you are currently taking:
____
Please list all surgical procedures you have had:
____

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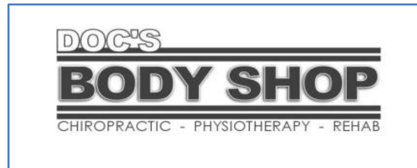

What activities do you do at work?

□ Sit:	□ Most of the day	□ Half the day	□ A little of the day
□ Stand:	□ Most of the day	□ Half the day	□ A little of the day
□ Computer work:	□ Most of the day	□ Half the day	□ A little of the day
□ On the phone:	□ Most of the day	□ Half of the day	□ A little of the day
□ Drive:	□ Most of the day	□ Half of the day	□ A little of the day
□ Perform manual labor	□ Read	□ Travel frequently	□ Other: __________

What activities do you do outside of work?

□ Bicycling	□ Hiking	□ Jogging	□ Swimming	□ Working out
□ Basketball	□ Walking	□ Golf	□ Softball	□ Other ___________

Have you ever been hospitalized?
□ No □ Previously mentioned □Yes, why? _________________________________

Have you seen a chiropractor before?
□ No □ Yes, what were the results? ____

Have you had any significant past trauma?
□ No □ Yes, what? ____

Is there anything else pertinent to your visit today?
□ No □ Yes, what? ____

Why Chiropractic?
People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so that Doc may be guided by your wishes whenever possible.
□ Stage 1: Pain relief: Just get rid of the pain, Doc! Relief is short-term.
□ Stage 2: Rehabilitation: Get rid of the pain, Doc, but then fix the problem so it doesn't come back!
□ Stage 3: Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise, and chiropractic so that I stay as healthy as possible.

We are a referral-based office and we thank you for trusting us with your care. Please take a minute to let us know how you heard about us.

____

____

Our mission is to treat you as we would our own family. If you have any questions, please do not hesitate to ask.

Patient Signature: ____________________________________ Date: ____________________

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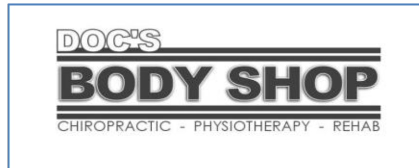

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can get access to this information. *Please Review it carefully*. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.
- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

- **Access:** You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.
- **Amendment:** You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer. Effective date 09/06/18.