BETTER BRAIN & BODY

PATIENT INTRODUCTION FORM

Name:_____ Today's Date:___/___/_____

Address:_____ City:_____ State:____ Zip:_____

Drivers License #:_____ Date of Birth:___/___/_____ Age:_____ Sex:_____

Phone: Home:_____ Work:_____ Cell:_____

Email:_____ SSN:_____

Occupation:_____ Employer:_____

Marital Status: Married:_____ Unmarried:_____ Spouse's Name:_____

How were you referred to our office? _____

Children

Name:_____ Age:_____

Name:_____ Age:_____

Name:_____ Age:_____

Insurance Information

Name of Insurance Company: _____ Relationship to Insured:_____

Name of Guarantor (Policy Holder):_____ Guarantor DOB:___/___/_____

Guarantor Employer:_____ Guarantor SSN:_____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize Better Brain & Body to furnish my insurance company with a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my chiropractic case, if requested by them.

I hereby authorize and direct payment to Better Brain & Body such sums as may be due on owing for chiropractic services rendered to me. I understand I am directly and fully responsible to Better Brain & Body for all medical bills submitted for services rendered to me. This agreement is made solely for Better Brain & Body's additional protection and in consideration of awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting Better Brain & Body's interest, Better Brain & Body will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to Better Brain & Body for services rendered.

Patient's Signature_____ **Date**_____

Better Brain & Body

PATIENT HEALTH HISTORY

Chief Complaints: What are the main reasons you are seeking treatment/evaluation?

1._____ For how long?_____

2._____ For how long?_____

3._____ For how long?_____

4._____ For how long?_____

Have you seen doctors for any of the above?_____

Please complete the following chart regarding prescription medications:

NAME	DAILY DOSAGE	REASON FOR TAKING

Please complete the following chart regarding current over-the-counter medications:

NAME	DAILY DOSAGE	REASON FOR TAKING

Please complete the following chart regarding current vitamin/nutritional supplements you are taking:

NAME	DAILY DOSAGE	REASON FOR TAKING

Please ***circle*** your best description: Overweight Average Underweight

Your height_____ Your weight_____ Any significant changes in the last year? YES NO

If yes, please describe:_____

(*Females Only)* Is there any possibility that you are pregnant? Yes_____ No_____

Do you use any of the following:

Caffeine Yes____ No____ How much/how often?_____

Alcohol Yes____ No____ How much/how often?_____

Cigarettes Yes____ No____ How much/how often?_____

Are you able to work without any limitations? Yes____ No____ If no, please describe:_____

_____

How often do you exercise? Never_____ Daily_____ Times per week_____ Times per month_____

Have you had to cut down on exercise or recreation because of your health? Yes_____ No_____

Rate your overall stress level using a scale of 1 (*very low*) through 10 (*very high*)_____

Do you suffer from fatigue? Yes____ No____ If yes, please describe:_____

_____

Do you have a pacemaker? Yes_____ No_____

Please describe all auto accidents or major injuries/falls in your lifetime:

DATE	DESCRIPTION

Please list all surgeries:

DATE	DESCRIPTION

For family no longer living (should this apply):

Age of Mother upon death_____ Cause of death_____

Age of Father upon death _____ Cause of death_____

Age of sibling (1) upon death _____ Cause of death_____

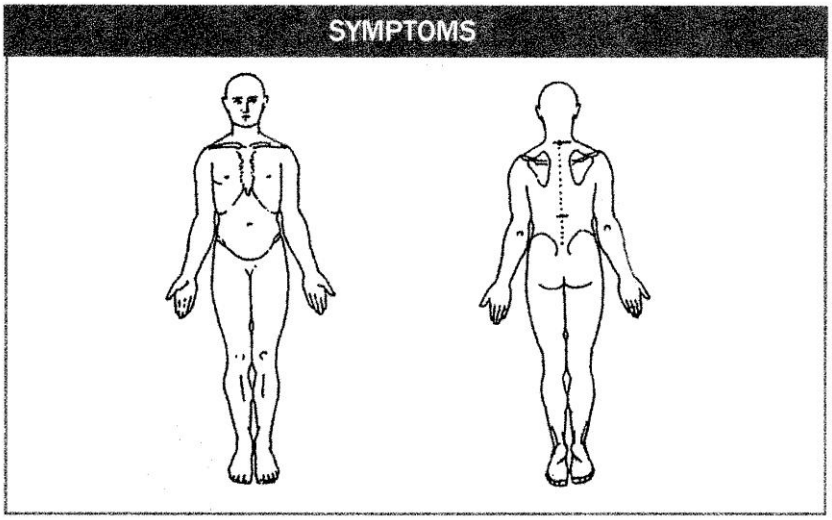
Age of sibling (2) upon death _____ Cause of death_____

Age of sibling (3) upon death _____ Cause of death_____

Please check any of the following problems that you have experienced in the past or are currently experiencing. If the condition does not apply to you, leave the columns blank.

Musculoskeletal			**Genito-Urinary**			**Gastrointestinal**		
	Past	**Present**		**Past**	**Present**		**Past**	**Present**
Neck pain			Bladder Infections			Acid reflux		
Pain between shoulders			Frequent Urination			Bloating/gas		
Low back pain			Painful Urination			Diarrhea		
Headaches			Leaking Urine			Constipation		
Arm or hand problems						Nausea		
Leg or feet problems			**(FEMALE)**			Diabetes		
Swollen joints			PMS			Liver Problems		
Painful joints			Painful menses			Gallbladder problems		
Stiff joints			Irregular menses			Weight problems		
Sore muscles			Mood Swings					
Carpal Tunnel						**Eye, Ear,**		
Fibromyalgia			**Nervous System**			**Nose, Throat**		
TMJ Pain			Numbness			Vision Problems		
			Loss of feeling			Ear pain		
Cardiovascular			Paralysis			Ringing/noises in ear		
Heart problems			Dizziness/Fainting			Hearing loss		
Chest pain			Fatigue			Sinus infections		
Difficulty breathing			Forgetfulness			Sinus headaches		
Blood pressure problems			Difficult Speech			Postnasal drip		
Mitral valve prolapse			Cold fingers or toes			Chronic cough		
Pacemaker			Trouble sleeping			Allergies		
Arrhythmias			Depression			Sore throat		

Please use the following diagram to mark all affected areas with the appropriate symbol:



xxx - PAIN
/// - NUMBNESS