BestLife
CHIROPRACTIC AND WELLNESS CENTER

5072 W. Plano Pkwy., Ste 130, Plano, TX 75093 (972) 200-5009
4401 Long Prairie Rd., Ste 200, Flower Mound, TX 75028 (972) 539-7500

Welcome to our office! *PLEASE PRINT AND COMPLETE ALL SECTIONS*

Appointment Date: _____ Referred By: _____
Name (first, middle, last) _____Preferred Name: _____
Mailing Address_____ City_____ State_____ Zip_____
Home (____)_____ Work (____)_____ Cell (_____)_____ Preferred Method _____
Social Security # _____ Date of Birth___/___/_____ Age_____ □Male □Female
Email: _____
Occupation_____Employer_____
Marital Status: □M □S □W □D Name of Spouse:_____
Names and Ages of Children: _____
Emergency Contact: _____ Relationship:_____ Phone: ( )_____

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	____ Prostate 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:	

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

1. Primary Complaint(s): _____
2. Secondary Complaint(s):_____
3. Tertiary Complaint(s):_____
4. Have you become discouraged about handling this problem? □ Yes □ No
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. How much older does this problem make you feel: _____
7. On a scale of 1 to 10, with 10 being the most, rate your commitment level in helping us solve this problem: _____
8. Tell us about your past medical history: What? When? Results?
   - Surgeries: _____
   - Hospitalizations: _____
   - Major Illness: _____
9. Are you currently taking anti-coagulant medication/therapy? □ Yes □ No

_____

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? _____

TELL US ABOUT YOUR HEALTH GOALS

1. What are your health goals? _____
2. How do you expect to achieve these goals? _____
3. What are you 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 my information is correct and that I have completed all questions as thoroughly as possible.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____

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FAMILY HEALTH HISTORY: *Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation "C" under his/her column, and those that are past health problems by the designation of "P" under his/her column. Leave blank those spaces that do not apply.*

	Father	Mother	Spouse	Siblings				Children			
Condition:	**Age:** _____	**Age:** _____	**Age:** _____	**Age:** ____	**Age:** ____	**Age:** ____	**Age:** ____	**Age:** ____	**Age:** ____	**Age:** ____	**Age:** ____
ADHD											
Allergies											
Arthritis											
Asthma											
Autism											
Back Trouble											
Bed Wetting											
Bursitis											
Cancer											
Chest Pain											
Colic											
Constipation											
Crohn's Disease											
Depression											
Diabetes											
Diarrhea											
Disc Problems											
Down Syndrome											
Ear Infection											
Emotion Issues											
Emphysema											
Epilepsy											
Headaches											
Migraines											
Heartburn											
Heart Trouble											
High Blood Press											
IBS											
Indigestion											
Infertility											
Insomnia											
Kidney Trouble											
Neck Pain											
Neuritis											
Nervousness											
Pinched Nerve											
Scoliosis											
Sinus Trouble											
Other: _____											

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

RELEASE AND CONSENTS

AUTHORIZATION FOR DIAGNOSIS AND TREATMENT
I authorize Best Life Chiropractic to administer diagnosis and treatment as deemed necessary by the doctors.

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.

Signature of Responsible Person: _____ Date: _____

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

AUTHORIZATION TO TREAT A MINOR CHILD

I authorize Best Life Chiropractic to administer diagnosis and treatment as deemed necessary by the doctors to my son/daughter

Child's Name: _____

Signature of Guardian: _____ Date: _____

Informed Consent
Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that it is responsible to let you know:

- Risk of stroke is reported to be 1 in 5-8 million or so... and the cause has yet to be determined.
- While extremely rare, there have been reports of ligament sprains, and even rib fractures reported.
- There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both, clinically and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in North America, Chiropractic is your safest health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor. I consent to the care recommended by my chiropractor and extend this consent to include all doctors of this Chiropractic & Wellness Center. This consent applies to all present and future care for me and my family.

Patient Name _____ **Date** _____

Patient/Guardian Signature_____ **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: _____
_____

Secondary and Tertiary Complaints

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. Since it began, your secondary complaint has: (please circle)
    Worsened Improved Stayed the Same
11. 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
12. If you have had surgery regarding this complaint, please describe here: _____
    _____

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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. Since it began, your tertiary complaint has: (please circle)
    Worsened Improved Stayed the Same
11. 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
12. If you have had surgery regarding this complaint, please describe here: _____
    _____

HIPAA Consents

Name of Practice: **Best Life Chiropractic and Wellness Center**
Address: 5072 W. Plano Parkway, Ste. 130 and 4401 Long Prairie Rd., Ste. 200
Plano, Texas 75093 Flower Mound, Texas 75028
Privacy Contact: Steven Le, D.C.
Telephone: 972-200-5009

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

NOTICE OF PRIVACY PRACTICE RECEIPT:
I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: X_____
Signature of Patient: X_____
Date: X_____
Patient's Date of Birth: X_____

For Personal Representative of the Patient (only if applicable)

Print Name of Personal Representative: X_____
Relationship (parent, guardian, etc.): X_____
Signature of Personal Representative: X_____
Reason Patient unable to sign: _____

_____ _____
Practice Employee Date

ALL PATIENTS PLEASE PROVIDE THE FOLLOWING
May we release appointment, billing and medical information to anyone other than you? ___YES ___NO

Name(s) of the person(s) we may release your information to: _____

* I hereby authorize Best Life Chiropractic and Wellness Centers to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.
* I authorize the release of any medical billing or other information necessary to process claims on my behalf.
* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Best Life Chiropractic and Wellness Center, Plano and Flower Mound, Texas.

_____ _____
Signature of Patient Date

_____
Print Name

Please initial one box below:
If our office attempts to contact you and a message is taken by an answering machine/voicemail or another person, it is appropriate to leave a:
____ Detailed message regarding condition, appointments, or payments.
____ Message to call Best Life Chiropractic and Wellness Center

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003
Revised According to New HIPAA Regulations September 23, 2013

Best Life Chiropractic and Wellness Center is committed to protecting your protected health information. "Protected Health Information" (PHI) 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 PHI 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 PHI; however, we are not required to approve your request.
- Request that we notify you about your PHI in a way or at a location that will help you keep your information confidential.
- Receive a list of certain disclosures we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years *except for disclosures made:*
    - For treatment, payment, and healthcare operations
    - For use in or related to a facility directory
    - To family members or friends involved in your care
    - To you directly
    - Pursuant to an authorization of you and your personal representative
    - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes)
    - Before April 14, 2003
- In writing at any time, withdraw your permission for us to disclose your PHI, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own PHI.
- Ask us to change your PHI 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 PHI:

The examples included with each category do not list every type of use or disclosure that may fall within that category.

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

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

HEALTHCARE OPERATIONS: We may use and disclose your PHI 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 PHI when required to do so by law. We may also use or disclose your PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability.
- To report disease, injury, birth or death.
- To report child abuse or neglect.
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA regulated products or activities.
- To locate and notify persons of recalls of products they may be using.
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.

- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

We may also use and disclose your PHI under certain circumstances for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency.
- To alert law enforcement of a death that we suspect was the result of criminal conduct.
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About a crime or suspected crime committed at the workplace.
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

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

RESEARCH: We may use your PHI 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, require the use or disclosure of your PHI.

OTHER USES: We may use and disclose your PHI to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care.

OBLIGATIONS OF BEST LIFE CHIROPRACTIC AND WELLNESS

- Maintain the privacy of your PHI.
- Provide you with the Notice of its legal duties and privacy practices with respect to your PHI.
- Obtain your written authorization to use or disclose your PHI 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 PHI is used or disclosed.
- Allow reasonable requests you may make to notify you about your PHI in a way or at a location that will help you keep your PHI confidential.

Best Life Chiropractic and Wellness reserves the right to change its information practices. The new provisions will be effective for all PHI 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 PHI, 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.