Boshell Chiropractic Clinic

Our Family caring for yours

M. Ray Boshell Jr. D.C. Amy D. Boshell D.C.

Confidential Patient Information

Name: _____ Date: _____

Address: _____ Phone: _____

City,State: _____ Zip:_____ Birthdate: _____

Social Security # _____-_____-_____ Sex: M F Type of Insurance:_____

Who is responsible for this bill?_____Method of Payment: Cash Check Credit Card Insurance

Employer: _____ Address: _____Work Phone: _____

Marital Status: M W D S Spouse's name: _____

Children's Names & Ages: _____

Favorite Hobbies or Interests: _____

List your main complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the pain? _____

Does the pain spread? Yes No If yes, where? _____

Do you have numbness? Yes No If yes, where? _____

Is it painful to cough or sneeze? Yes No If yes, where? _____

Is it painful to go from a sit to a stand? Yes No If yes, where? _____

Do You Have headaches? Yes No Circle those that apply. Tension Throb Sinus Migraine

Circle any function below that aggravate or are aggravated by your condition:

Walking Vision Driving Working Recreation Digestion Bowel Movements

Sleeping Breathing Sinuses Hearing Smelling Menstrual Step Climbing

Have you ever been to a chiropractor before? Yes No If yes, when? _____

List other doctors that were consulted for these conditions: 1. _____ 2. _____

Previous diagnosis given: _____

List operations you have had: 1._____ 2._____ 3._____

List any serious illness you have had:_____

Date of last physical examination: _____ Could you be pregnant? Yes No

Have you ever been diagnosed with cancer? Yes No If yes, what kind? _____

List any medication you are currently taking:_____

Has any of your family had similar problems either now or in the past? Yes No If yes, who?_____

Confidential: Please let the doctor know if you are HIV positive, or if you have any other communicable diseases. (i.e., TB, Hepatitis, etc.)

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Pneumonia
Rheumatic Fever
Polio
Tuberculosis
Whooping Cough
Anemia
Measles
Mumps
Smallpox
Chicken Pox
Diabetes
Cancer
Heart Disease
Thyroid
Influenza
Pleurisy
Arthritis
Epilepsy
Mental Disorders
Lumbago
Eczema

INTAKE
Coffee
Tea
Alcohol
Cigarettes
White Sugar

CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
Low Back Pain
Pain Between Shoulders
Neck Pain
Arm Pain
Joint Pain/Stiffness
Walking Problems
Difficulty Chewing/Clicking Jaw
General Stiffness

NERVOUS SYSTEM CODE
Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities
Stress

GENERAL CODE
Fatigue
Allergies
Loss of Sleep
Fever
Headaches

Gas/Bloating After Meals
Heartburn
Black/Bloody Stool
Colitis

GENITO/URINARY CODE
Bladder Trouble
Painful/Excessive Urination
Discolored Urine

C-V-R CODE
Chest Pain
Short Breath
Blood Pressure Program
Irregular Heartbeat
Heart Program
Lung Programs/Congestion
Varicose Veins
Ankle Swelling
Stroke

EENT CODE
Vision Program
Dental Program
Sore Throat
Earaches
Hearing Difficulty
Stuffed Nose

Prostate Sexual Dysfunction
Other Problems
_____
_____
_____

GASTROINTESTINAL CODE
Poor/Excessive Appetite
Excessive Thirst
Frequent Nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Problems
Gall Bladder Problems
Weight Trouble
Abdominal Cramps

FEMALES ONLY
When was your last period?
_____

Are you pregnant?
_____

MALE/FEMALE CODE
Menstrual Irregularity
Menstrual Cramps
Vaginal Pain/Infection
Breast Pain/Lumps

FAMILY HISTORY
The following members have the same or similar problem(s) as I do:
Mother
Father
Brother
Sister
Spouse
Child

BOSHELL CHIROPRACTIC CLINIC

8177 HWY 13 SOUTH/ P.O. BOX B
HALEYVILLE, AL 35565

Phone: 486-2000

M. Ray Boshell Jr. D.C. Amy D. Boshell D.C.

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Boshell Chiropractic Clinic

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 8177 Highway 13 South, Haleyville, AL 35565. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative's Authority