Bowen Chiropractic and Wellness Center

P.O. Box 366 / 794 South Highway 89
Chino Valley, AZ 86323 928-636-7682

Name:		Age:	Date:	Case #
Mailing Address:		City	State	Zip
Physical Address:		City	State	Zip
Phone: (H)	(C)	Fax:	E-mail	
Date of Birth:	Sex: M ❑ F ❑	Marital Status: S ❑ M ❑ D ❑ W ❑		_____# of Children
Occupation:	Employer:		Telephone (Work)	Ext.
Social Security Number		Driver's License Number		State
Insured's Name		Phone	Insured's DOB	
Insurance Company		Telephone		
Spouse's Name		Spouse's Occupation		
Spouse's Employer		Spouse's Telephone (Work)		
Spouse's Insurance Company		Telephone		
Spouse's Social Security Number		Spouse's Driver's License Number		State
Emergency Contact		Relationship	Contact Number	
Previous Chiropractic Care: Yes❑ No❑ When?		Doctor's Name:		
Results:		How did you hear about us?		

Are your present problems due to an injury? No ❑ Yes ❑ On the Job ❑ Auto Accident ❑ Personal Injury ❑ Other ❑

Has your accident been reported? No ❑ Yes ❑ To Employer ❑ Auto Carrier ❑ Other ❑ _____

Are you now or have you ever been disabled? (Service or Work) No ❑ Yes ❑ When? _____ Why? _____

Have you retained an attorney? No ❑ Yes ❑ Name and Address

Pain Symptoms: (In order of severity)	1. _____	Began-(Mo/Yr) _____ Previous Episodes _____
	2. _____	Began-(Mo/Yr) _____ Previous Episodes _____
	3.	Began-(Mo/Yr) _____ Previous Episodes _____

Please mark the intensity of your pain today.

0 - NO PAIN
10 - INTENSE PAIN

Example Neck
O 1 2 3 ④ 5 6 7 8 9 10

1. _____
O 1 2 3 4 5 6 7 8 9 10

2. _____
O 1 2 3 4 5 6 7 8 9 10

3. _____
O 1 2 3 4 5 6 7 8 9 10

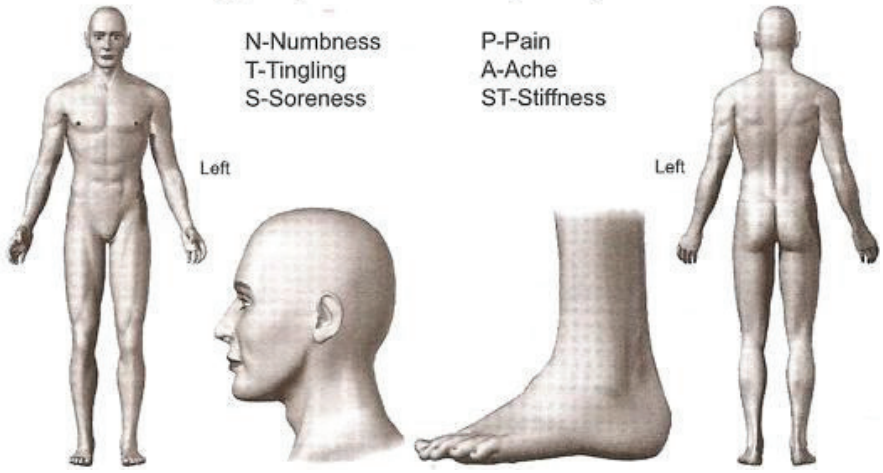
DOCTORS USE ONLY

_____
_____
_____
_____

Please mark area & type of pain on the drawings using the codes listed below.

N-Numbness
T-Tingling
S-Soreness

P-Pain
A-Ache
ST-Stiffness



HABITS

❑ Smoking Packs/Day: _____
❑ Drinking Alcohol: _____
❑ Caffeine Cups/Day: _____

EXERCISE

❑ None
❑ Light Activity
❑ Moderate Activity
❑ Active
❑ Very Active
❑ Elite Athlete

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Other
Mother	❑	❑	❑	❑	❑ _____
Father	❑	❑	❑	❑	❑ _____
Brother,# of:____	❑	❑	❑	❑	❑ _____
Sister,# of: ____	❑	❑	❑	❑	❑ _____

HAVE YOU HAD, OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ 541	Appendicitis	❑ 280	Anemia	❑ 429.9	Heart Disease	❑ 716	Arthritis
❑ 480	Pneumonia	❑ 055	Measles	❑ 240	Goiter	❑ 345	Epilepsy
❑ 390	Rheumatic Fever	❑ 072	Mumps	❑ 487	Influenza	❑ 319	Mental Disorder
❑ 045	Polio	❑ 052	Chicken Pox	❑ 511	Pleurisy	❑ 724.2	Lumbago
❑ 011	Tuberculosis	❑ 250	Diabetes	❑ 303.9	Alcoholism	❑ 690	Eczema
❑ 033	Whooping Cough	❑ 239	Cancer	❑ 099	Venereal Disease	❑ 042	HIV Positive
❑ 493.9	Asthma	❑ 346.9	Migraine Headaches	❑ 054.9	Herpes	❑ 340	Multiple Sclerosis

(OVER)

Please check the correct box for each item below. Check at least one box for each sign or symptom listed. ❑ Never ❑ Previously ❑ Presently.

Never	Previously	Presently	GENERAL SYMPTOMS	
❑	❑	❑	995.3	Allergy (What)____
❑	❑	❑	490	Bronchitis
❑	❑	❑	780.9	Chills
❑	❑	❑	780.39	Convulsions
❑	❑	❑	780.4	Dizziness
❑	❑	❑	780.2	Fainting
❑	❑	❑	780.79	Fatigue
❑	❑	❑	780.6	Fever
❑	❑	❑	784.0	Headache
❑	❑	❑	780.52	Loss of Sleep
❑	❑	❑	783	Loss of Weight
❑	❑	❑	799.2	Nervousness
❑	❑	❑	729.2	Neuralgia
❑	❑	❑	780.8	Sweats
❑	❑	❑	786.07	Wheezing
❑	❑	❑	311	Depression

Never	Previously	Presently	GASTRO-INTESTINAL	
❑	❑	❑	787.3	Belching/Gas/Bloating
❑	❑	❑	789.0	Abdominal Pain
❑	❑	❑	564.0	Constipation
❑	❑	❑	787.91	Diarrhea
❑	❑	❑	783.6	Excessive Eating
❑	❑	❑	575.9	Gall Bladder Trouble
❑	❑	❑	455	Hemorrhoids (piles)
❑	❑	❑	782.4	Jaundice
❑	❑	❑	794.8	Liver Trouble
❑	❑	❑	787.02	Nausea
❑	❑	❑	536.9	Stomach Pain
❑	❑	❑	783.0	Poor Appetite
❑	❑	❑	536.8	Poor Digestion
❑	❑	❑	787.03	Vomiting
❑	❑	❑	578.0	Vomiting Blood
❑	❑	❑	783.5	Excessive Thirst
❑	❑	❑	536.8	Indigestion
❑	❑	❑	569.3	Rectal Bleeding

Never	Previously	Presently	EYE/EAR/NOISE/THROAT	
❑	❑	❑	493.9	Asthma
❑	❑	❑	378.9	Crossed Eyes
❑	❑	❑	389.9	Deafness
❑	❑	❑	388.70	Earache
❑	❑	❑	388.60	Ear Discharge
❑	❑	❑	388.30	Ear Noises
❑	❑	❑	240.9	Enlarged Thyroid
❑	❑	❑	460	Frequent Colds
❑	❑	❑	477	Hay Fever
❑	❑	❑	784.49	Hoarseness
❑	❑	❑	478.1	Nasal Obstruction
❑	❑	❑	784.7	Nosebleeds
❑	❑	❑	379.91	Pain in Eyes
❑	❑	❑	368.9	Poor Vision
❑	❑	❑	461.9	Sinusitis
❑	❑	❑	462	Sore Throat
❑	❑	❑	463	Tonsillitis
❑	❑	❑	786.2	Persistent Cough
❑	❑	❑	787.2	Difficulty Swallowing
❑	❑	❑	523.8	Bleeding Gums

Never	Previously	Presently	RESPIRATORY	
❑	❑	❑	786.50	Chest Pain
❑	❑	❑	786.2	Chronic Cough
❑	❑	❑	786.09	Difficulty Breathing
❑	❑	❑	786.3	Spitting Blood
❑	❑	❑	786.4	Spitting Phlegm

GENITO-URINARY

❑	❑	❑	788.36	Bed Wetting
❑	❑	❑	599.7	Blood in Urine
❑	❑	❑	788.4	Frequent Urination
❑	❑	❑	788.3	Lack of Bladder Control
❑	❑	❑	590.9	Kidney Infection
❑	❑	❑	788.1	Painful Urination
❑	❑	❑	601.9	Prostate Trouble

			MUSCLES/JOINTS/BONES	
❑	❑	❑	724.5	Backache
❑	❑	❑	719.7	Foot Trouble
❑	❑	❑	550	Hernia
❑	❑	❑	719.1	Pain Between Shoulders
❑	❑	❑	724.6	Painful Tail Bone
❑	❑	❑	723.9	Stiff Neck
❑	❑	❑	781.9	Spinal Curvature
❑	❑	❑	719.0	Swollen Joints
❑	❑	❑	781.0	Tremors/Twitching
❑	❑	❑	782	Arm Trouble

			CARDIO-VASCULAR	
❑	❑	❑	401.9	High Blood Pressure
❑	❑	❑	458.9	Low Blood Pressure
❑	❑	❑	786.51	Pain Over Heart
❑	❑	❑	785.9	Poor Circulation
❑	❑	❑	438	Previous Heart Trouble
❑	❑	❑	785.0	Rapid Heart
❑	❑	❑	427.89	Slow Heart
❑	❑	❑	436	Strokes
❑	❑	❑	719.7	Swelling Ankles
❑	❑	❑	454	Varicose Veins

			SKIN OR ALLERGIES	
❑	❑	❑	680.9	Boils
❑	❑	❑	924.9	Bruising Easily
❑	❑	❑	701.1	Dryness
❑	❑	❑	691.8	Eczema
❑	❑	❑	708.9	Hives or Allergy
❑	❑	❑	698.9	Itching
❑	❑	❑	782.0	Sensitive Skin
❑	❑	❑	782.1	Skin Eruptions

FOR WOMEN ONLY

❑	❑	❑	625.3 Cramps or Backaches
❑	❑	❑	626.2 Excessive Flow
❑	❑	❑	627.2 Hot Flashes
❑	❑	❑	626.4 Irregular Cycle
❑	❑	❑	634.9 Miscarriage
❑	❑	❑	625.3 Painful Periods
❑	❑	❑	623.5 Vaginal Discharge
❑	❑	❑	611.79 Lump in Breast

❑ Yes ❑ No Pregnant at this time?

❑ Yes ❑ No Have you had a mammogram?

_____ Last Pap Smear Date

_____ By Whom

OPERATIONS AND PROCEDURES

DATE		DATE		DATE	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other:_____	_____	Other:_____	_____	Other:_____

❑ I have never had any operations / surgeries

List any accidents or falls and dates: ❑ Car:_____ ❑ Recreation:_____

❑ Sports:_____ ❑ School:_____ ❑ Other: _____

List any broken bones (fractures) or dislocations: _____

Ever on crutches? ❑ Yes ❑ No Why? _____

Have you ever had any spinal taps or spinal injections? ❑ Yes ❑ No Were you ever knocked unconscious? ❑ Yes ❑ No

Have you ever had a lapse of memory? ❑ Yes ❑ No

Have you ever had X-rays taken? ❑ Yes ❑ No When?_____ By Whom?_____

For what ailments were these X-rays made? _____

Do you suffer from any condition other than that for which you are now consulting us? _____

Are you presently taking any medication - prescription or over-the-counter? ❑ Yes ❑ No What drugs? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. The Doctor's office will prepare reports and forms necessary to assist me in the filing of my claim with the insurance company but cannot guarantee reimbursement from the insurance company. Direct payments made from the insurance company to the Doctor's office will be credited to my account upon receipt and any balances due will be my responsibility. All services rendered to me are my personal responsibility and I agree to make payment for these services to the Doctor's office. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable. Should third party collection become necessary, I agree to pay all fees involved in collection of the account.

I authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The amount paid to the Doctor's office for X-rays is for the examination only; the X-ray negatives will remain the property of the Doctor's office and will remain on file at the Doctor's office as long as I am a patient. I am the responsible party for payment of any treatment received or incurred on this account. This Doctor provides only chiropractic care and is not responsible for any pre-existing medically diagnosed conditions or for making any medical diagnosis.

Patient's/Guardian's Signature: X_____ Date:_____

Bowen Chiropractic and Wellness Center

Meaningful Use Form

Patient's Name: _____ # _____ Date of Birth: _____

We are now mandated by law to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please Check ONE in EACH CATEGORY that applies)

RACE		ETHNICITY	PREFERRED LANGUAGE
☐ White ☐ Hispanic or Latino	☐ More Than One Race ☐ American Indian	☐ Hispanic or Latino	☐ English
☐ Black or African American	☐ Native Hawaiian ☐ Other Pacific Islander	☐ Not Hispanic or Latino	☐ Spanish
☐ Asian ☐ Alaskan Native	☐ Refused to Report	☐ Refused to Report/Unreported	☐ Other ☐ Refused to Report

I give permission for the office to call all contact numbers with appointment reminders: Yes No

Patient's Email Address: _____

I request my daily records printed each visit ☐ or I will request as needed ☐

I prefer to be contacted by: email ☐regular mail ☐ secure cell phone ☐home phone ☐ text ☐

☐Yes ☐ No Monthly Newsletter emailed and Special Promotions

ARE YOU A SMOKER OR HAVE YOU BEEN A SMOKER? (Please Check the ONE that applies)				
☐ Current Everyday	☐ Current Some	☐ Former Smoker	☐ Never Smoked	☐ Unknown
HOW DID YOU HEAR ABOUT US? (Please Check the ONE that applies)				
☐ Family/Friend Who_____	☐ Newspaper Name_____	☐ Other Name_____	☐ Provider List Name_____	☐ Doctor Name_____
☐ Church	☐ Dex ☐ Action Pages	☐ Mailer	☐ Radio	☐ Sign out front
☐ Seminar Event-Screening	☐ Sports	☐ CDL Physical	☐ Worker's Comp	☐ Internet Search

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion.

Medication	Milligrams	How and How Often You Taken	Reason for taking	Date Started
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any known allergies:

No Known allergies _____

_____ _____

Reaction: Nausea ___ Vomiting___ Diff. Breathing___ Rash___ Other:_____

_____ _____

Reaction: Nausea ___ Vomiting___ Diff. Breathing___ Rash___ Other:_____

By signing below, I give permission for you to update my Medication History

By signing I authorize the listed person or persons to be informed of my protected health information. _____ ☐ I withdraw my consent to update

_____ _____ _____

Signature of Patient, Guardian or Legal Representative Date

FOR OFFICE USE ONLY

Height_____ Init___ **Weight**_____ Init___ **BP**_____**rt/lt** Init___ **Pulse**_____ Init___

Confirm Personal Demographics_____ Chart#_____ Initial_____ Date_____