Body Freedom - Personal Info & Demographics

Date: _____

Name _____

Age _____ Date of Birth ____ / ____ / _____

Marital Status _____

E-mail Address _____

Home No. _____ Cell No. _____

Occupation _____

How did you hear about us? _____

1) I have read the instructions to prepare for the Body Freedom session.
2) I have read the instructions on how to get on a Zoom meeting live.
3) I have read the post treatment section, to prepare for my Body Freedom session.

I understand that payment is due prior to my Body Freedom session and understand that I am ultimately responsible for payment in full at this office.

Signed _____ Date _____

Dr Racine Health / Body Freedom

Body Freedom treatment sessions will be via Zoom meetings, where treatments are to be done remotely.

Body Freedom typically runs 60 – 90 minutes.

Body Freedom costs are typically $100 - $200 per session. Costs will be determined prior to the meeting.

Payment will be made through Racine Chiropractic Center.

CREDIT CARD: ☐ AMEX ☐ VISA ☐ MC ☐ DISCOVER

CARDHOLDER NAME _____

CARD # _____

EXP DATE _____ / _____

CCV # on back of card _____ ZIP CODE assoc. with card _____

I agree to the terms and authorize Racine Chiropractic Center to process payment, on this credit card - for Body Freedom sessions. If I miss the appointment, or no-show, or cancel with less than a 24 hours notice - I forfeit the fee for that Body Freedom session.

X _____

Signature

PATIENT HISTORY

Last Name _____ First Name _____

Date of Birth _____ Social Security Number _____ - _____ - _____

Your Occupation _____

Have you ever been to another doctor for this problem? Y / N Who? _____

Have you been to a chiropractor in the last 3 years? Y / N

Who referred you to this office? _____

WHAT BRINGS YOU TO OUR OFFICE?

PRIMARY COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin ___ Gradual ___ Sudden ___ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain ___ Sharp ___ Dull ___ Ache ___ Burn ___ Throb
- Does the Pain Radiate anywhere? Y / N ___ Arm ___ Leg ___ Head
- Do you experience Numbness or Tingling? ___ Y ___ N
- How often do you experience these symptoms?

___ Daily ___ 1-2 x Week ___ 1-2 x Month ___ Constant ___ Other

- **PAIN INTENSITY:** Circle the intensity of your pain, on a scale 1-10... 10 being the worst.

1 2 3 4 5 6 7 8 9 10

OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin ___ Gradual ___ Sudden ___ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain ___ Sharp ___ Dull ___ Ache ___ Burn ___ Throb
- Does the Pain Radiate anywhere? Y / N ___ Arm ___ Leg ___ Head
- Do you experience Numbness or Tingling? ___ Y ___ N
- How often do you experience these symptoms?

___ Daily ___ 1-2 x Week ___ 1-2 x Month ___ Constant ___ Other

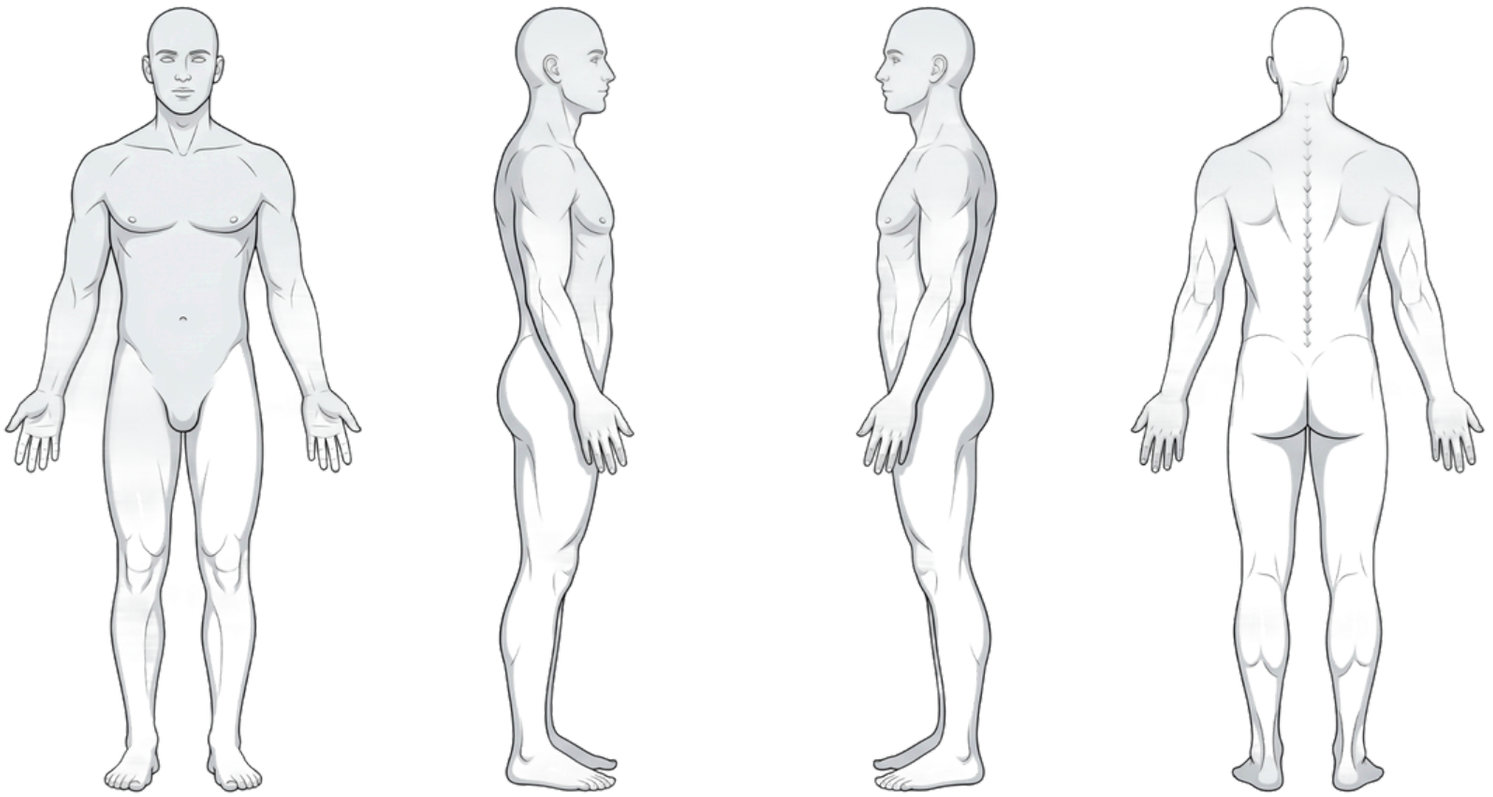
- **PAIN INTENSITY:** Circle the intensity of your pain, on a scale 1-10... 10 being the worst.

1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE _____ **DATE** _____

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramp/Tension

PATIENT SIGNATURE _____ **DATE** _____

PATIENT HISTORY

Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed _____

Name of Treating Physician _____ Dates of Treatment _____

Type of Treatment or Drugs Prescribed _____

Please list all past surgeries:

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

Please list any previous auto accidents, accidents and falls(even if sought NO treatments for it) :

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking:

_____
_____
_____

Other problem areas: check off... or make 'yes' or 'no'

- ☐ Insomnia
- ☐ Fatigue
- ☐ Stress
- ☐ TMJ
- ☐ Shoulder Problems
- ☐ Elbow / Elbow pain
- ☐ Leg Problems
- ☐ Knee Problems
- ☐ Foot Problems
- ☐ Disc Problems
- ☐ Arthritis
- ☐ Scoliosis

Any Immune Problems? Y / N
Any Eye, Ear, Nose, or Throat? Y / N
Any Heart Problems? Y / N
Any Lung Problems? Y / N
Any Breast Problems? Y / N
Any Urinary Problems? Y / N
Any Thyroid or Diabetes? Y / N
Any Mental – Emotional issues? Y / N
Any Allergies? Any Asthma? Y / N
List other conditions you think are relevant: _____
_____
_____

PATIENT SIGNATURE _____ **DATE** _____

Dr Racine New Patient Questionnaire

In order to look at a more complete view of your health & well being, please rate the following. On a scale of 1 – 10, 10 being the best

- How is your overall health ? 1 – 10 (_____)
- How is your overall body health ? 1 – 10 (_____)
- How is your overall mental health ? 1 – 10 (_____)
- How is your overall spiritual health ? 1 – 10 (_____)
- How is your overall sleep quality ? 1 – 10 (_____)
- What time do you wake up ? (_____ AM) What time do you go to sleep ? (_____ PM)
- How old is your mattress ? (_____ years)
- How is your overall energy levels ? 1 – 10 (_____)
- How many hours outdoors, to you spend daily on average ? (_____)
- How is your overall Joy of life ? 1 – 10 (_____)
- How would you rate your overall diet ? 1 – 10 (_____)
- How would you rate your overall exercise & stretch routine ? 1 – 10 (_____)
- How would you rate your overall body movement ? 1 – 10 (_____)

Q : How much better are you expecting to get? 0% _____ 100%

Q : In what time frame, are you expecting to get better by ?

_____ hours _____ days _____ weeks _____ months _____ years