BalancedBody chiropractic

New Patient Form

Clear Form | Print Form

Please fill out completely.

PERSONAL INFORMATION

Today's Date:

Patient Name: SSN:

Address: City: State: Zip:

Home Phone: Cell Phone: Email:

Date of Birth: Age: Sex: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor Children: ☐ Yes ☐ No How Many?

Spouse's Name: How were you referred to our office?

INSURANCE INFORMATION

Insurance Company Name: Phone:

Address: City: State: Zip:

Subscriber's Name: I.D. # Group #

Subscriber's DOB: Subscriber's Employer: Relation to Subscriber:

EMPLOYMENT/SCHOOL INFORMATION

Employer/School: Occupation:

Address: City: State: Zip:

EMERGENCY CONTACT INFORMATION

Name: Relation:

Home Phone: Work Phone: Cell Phone:

Medical Doctor: Phone:

PATIENT CONDITION

Reason for visit?

Is this related to: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic ☐ Accident Other:

Rate the severity of your pain from 0 (no pain) to 10 (extreme pain): When did it begin?

Is it getting worse? ☐ Yes ☐ No Is it constant? ☐ Yes ☐ No Have you had a similar condition in the past? ☐ Yes ☐ No

Have you had X-rays, CT scan, MRI or other tests for this condition? ☐ Yes ☐ No

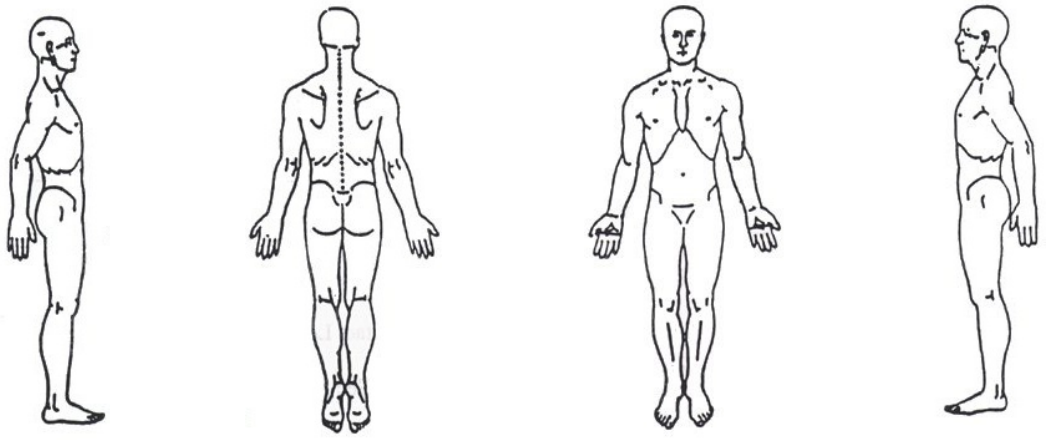
What treatments have you received for this condition? ☐ None ☐ Medications ☐ Surgery ☐ PT ☐ Chiropractic ☐ Other

Does it interfere with: ☐ Work ☐ Daily Routine ☐ Recreation ☐ Sleep ☐ Other Explain:

What makes it feel better? ☐ Nothing ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Rest ☐ Movement

What makes it feel worse? ☐ Nothing ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Rest ☐ Movement

Please use the following figure and letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.
(A=Aching B=Burning C=Cramps D=Dull N=Numbness O=Other S=Stabbing Sh=Sharp St=Stiffness Sh=Shooting T=Tingling Th=Throbbing)



Describe pain and location:

HEALTH INFORMATION

Do you have or ever had any of the following conditions? (Please check all that apply.)

Musculoskeletal
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Arm/Elbow Pain
- ☐ Hand/Wrist Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Upper Leg/Hip Pain
- ☐ Lower Leg/Knee Pain
- ☐ Ankle/Foot Pain
- ☐ Jaw Pain/TMJ
- ☐ Arthritis
- ☐ Joint Stiffness
- ☐ Fractures
- ☐ Herniated Disc
- ☐ Muscular Dystrophy
- ☐ Muscular Incoordination
- ☐ Artificial Bones/Joints
- ☐ Osteoporosis
- ☐ Gout

Cardiovascular
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Aortic Aneurysm
- ☐ Angina
- ☐ Irregular Heartbeat
- ☐ Chest Pains
- ☐ High/Low Blood Pressure
- ☐ Heart Surgery/Pacemaker
- ☐ Poor Circulation

Urinary
- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Loss of Bladder Control
- ☐ Bladder Infection

General
- ☐ Weight Loss/Gain
- ☐ Fatigue/Lack of Energy

Neurologic
- ☐ Stroke
- ☐ Epilepsy/Seizures
- ☐ Convulsions
- ☐ Dizziness/Vertigo
- ☐ Severe Headaches
- ☐ Concussion
- ☐ Pinched Nerve
- ☐ Parkinson's Disease
- ☐ Numbness
- ☐ Fainting
- ☐ Visual Disturbances

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Stress

Eyes
- ☐ Glaucoma
- ☐ Neuritis
- ☐ Double/Blurred Vision

Respiratory
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Chronic Cough

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Menstrual
- ☐ Menopausal

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Colitis
- ☐ Irritable Bowl Syndrome
- ☐ Liver Disease
- ☐ Indigestion
- ☐ Ulcers
- ☐ Constipation
- ☐ Gallbladder Disease
- ☐ Loss of Appetite

Immunologic
- ☐ HIV/AIDS
- ☐ Multiple Sclerosis

Reproductive
- ☐ Prostate Disease
- ☐ Breast Soreness/Lumps
- ☐ Endometriosis

Hematologic
- ☐ Hepatitis
- ☐ Cancer
- ☐ Blood Disorder

Ear, Nose and Throat
- ☐ Chronic Sinusitis
- ☐ Tinnitus
- ☐ Difficulty Swallowing

Other
- ☐ Tumors
- ☐ Dermititis
- ☐ Rheumatic Fever
- ☐ Polio

Please list any additional major illness/injury:

Surgeries/Treatments: Medications:

Family health history (Example: cancer, heart disease, etc.):

Present Weight: Lbs. Present Height: Ft. In. Do you exercise? ☐ Yes, daily ☐ Yes, occasionally ☐ No

Allergies: Vitamins/Supplements:

Do you smoke? ☐ Yes ☐ No Amount: Do you drink caffeine? ☐ Yes ☐ No Amount:

Do you drink alcohol? ☐ Yes ☐ No Amount: Hours of work per day: Hours of sleep per night:

For Women: Are you pregnant? ☐ Yes ☐ No Due Date: How Many Births? Nursing? ☐ Yes ☐ No

CONDITIONS OF REGISTRATION

1. GENERAL CHIROPRACTIC CONSENT. The patient or the person legally authorized to consent for medical care on the patient's behalf hereby consents to chiropractic care, including but not limited to spinal manipulation, rendered to the patient under the general and special instructions of the chiropractor. I understand and am informed that, as with any healthcare procedure, in the practice of chiropractic there are some material risks inherent to treatment, including but not limited to fractures, disc injuries, dislocations and sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. However, if I have a condition that would otherwise not come to the doctor's attention, it is my responsibility to inform the doctor. I accept full responsibility for treatment and I release Balanced Body Chiropractic and its doctors from any and all liability in the unlikely event that a problem occurs from my treatment.

2. RELEASE OF INFORMATION. To the extent necessary to determine responsibility for payment and to obtain reimbursement, Balanced Body Chiropractic may disclose pertinent portions of the patient's financial or medical records to insurance companies, health care service plans, worker's compensation carriers, corporations or persons who are or may be responsible for all or any portion of the patient's account. Patient's information may also be released to the referring physician and other health facilities to ensure continuity of care.

3. ASSIGNMENT OF INSURANCE BENEFITS. The patient or the patient's legal representative authorizes payment directly to Balanced Body Chiropractic of any insurance benefits, both basic and chiropractic, otherwise payable to or on behalf of the patient for all services rendered during the entire course of treatment and care by Balanced Body Chiropractic. I authorize the use of my signature on all insurance submissions.

4. FINANCIAL AGREEMENT. In consideration of the chiropractic services to be rendered, the patient or the patient's guarantor signing on the patient's behalf hereby agrees to accept full financial responsibility for the patient's account in accordance with the rates and terms of any contracts between Balanced Body Chiropractic, patient and the insurance company if Balanced Body Chiropractic contracts with the insurance company. Medicare patients are responsible for all deductibles, co-insurance or co-payments as applicable.

I, the undersigned, certify that all of the above information is complete and accurate to the best of my knowledge. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I have also read, or have had read to me, the above consent and had an opportunity to ask questions about its content, and by signing below I agree to and request chiropractic care having been informed of the risks. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Balanced Body Chiropractic.

Patient or Parent/Legal Guardian (if minor):

Print Name: _____ Relation (if other than patient): _____

Signature: _____ Date: _____

Doctor or Staff:

Witness Signature: _____ Date: _____