Back In Balance Chiropractic, LLC

Date_____

Name _____ What do you prefer to be called_____

Address_____ City_____ State_____ Zip Code_____

Birth Date: ____/____/_____ Social Security Number:_____-_____-_____ Height: _____Weight:_____

E-mail_____ Home Phone (____)_____-_____ Cell (____)_____-_____

Contact Preference: ☐Home Phone ☐Cell Phone ☐Email ☐Postal Mail

Emergency Contact: _____ Phone: (_____) _____-_____

Work status: ☐Working ☐Unemployed ☐Disabled ☐Retired ☐Homemaker

Occupation /Employer (current/most recent):_____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Spouse's Name_____ Spouse's Employer_____

Do you have any children? ☐No ☐Yes, How many?_____

Who referred you to our office? _____ Who is your Family Dr._____

Have you ever been to a chiropractor or acupuncturist before? ☐No ☐Yes Who:_____

Is your visit due to an auto or work related accident? ☐No ☐Yes

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- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I have had an opportunity to review the clinics HIPAA policy and have been afforded an opportunity to receive a copy of it and understand that I may ask for one at any time.

_____ _____ _____

Printed Name Signature Date

Name: _____ **Date:**_____

Do you have Allergies? ☐Food ☐Environmental ☐Medication ☐None

List type of Allergy and Reaction(s):

_____
_____
_____

Medications/ Vitamins/ Supplements (*Please list both prescription and non-prescription)* ☐ None

_____
_____
_____

Surgical History: ***(Please list all previous surgeries, the surgeon and date***) ☐ None

_____
_____
_____

Review of Systems: *Please circle any condition you are **currently** experiencing.*

Constitutional: Fever Weight loss Weight gain Chills Other _____
Neurologic: Headache Dizziness Memory Loss Numbness Other _____
Eyes: Glasses Contacts Double vision Blurriness Other _____
Ears/Throat: Deafness Ringing Hoarseness Swallowing difficulty Other _____
Cardiac: Chest pain Skip beats Rapid beat Edema/ankle swelling Other _____
Pulmonary: Cough Cough blood Short of breath Wheezing Other _____
Intestinal: Diarrhea Bleeding Incontinence Constipation Other _____
Urinary: Burning Bleeding Incontinence Increased Frequency Other _____
Musculoskeletal: Pain Weakness Arthritis Joint Swelling Cane/walker Other _____
Skin: Bruising Lesions Birth marks Other _____
Hematologic: Bleeding Transfusions Hepatitis Other _____
Psychiatric: Depression Insomnia Fatigued Nervous exhaustion Other _____
Miscellaneous: Metal implants Breast Implants Claustrophobic Other _____

Family History:
Please check any problems that run in your family.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Multiple Sclerosis	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Heart Problem	☐	☐	STD's
☐	☐	Anemia	☐	☐	HIV/ARC	☐	☐	Sinus Trouble
☐	☐	Arthritis	☐	☐	High Blood Pressure	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Kidney Trouble	☐	☐	Thyroid Trouble
☐	☐	Cancer	☐	☐	Spinal Disc Disease	☐	☐	Tuberculosis
☐	☐	Bone Fracture	☐	☐	Low Blood Pressure	☐	☐	Ulcer
☐	☐	Cirrhosis/Hepatitis	☐	☐	Mental/Emotional	☐	☐	Polio
☐	☐	Diabetes			Difficulty	☐	☐	Scoliosis
☐	☐	Dislocated Joints	☐	☐	Prostate Trouble	☐	☐	Diverticulitis

Other: _____

Medical History:
Do you have or have you had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Gout	☐	☐	Scoliosis
☐	☐	Allergies	☐	☐	Hay Fever	☐	☐	Sinus Trouble
☐	☐	Anemia	☐	☐	Heart Problem	☐	☐	Spinal Disc Disease
☐	☐	Arthritis	☐	☐	High Blood Pressure	☐	☐	Thyroid Trouble
☐	☐	Asthma	☐	☐	HIV/ARC	☐	☐	Tuberculosis
☐	☐	Bone Fracture	☐	☐	Kidney Trouble	☐	☐	Ulcer
☐	☐	Blood Thinners	☐	☐	Low Blood Pressure	☐	☐	Polio
☐	☐	Cancer	☐	☐	Mental/Emotional	☐	☐	Epilepsy
☐	☐	Cirrhosis/Hepatitis			Difficulty	☐	☐	_____
☐	☐	Diabetes ☐I ☐II	☐	☐	Prostate Trouble	☐	☐	_____
☐	☐	Dislocated Joints	☐	☐	Rheumatic Fever	☐	☐	_____
☐	☐	Diverticulitis	☐	☐	STD's			

Other: _____

Social History:

❖**Tobacco use**: ☐Never ☐Former Smoker ☐Current/Every Day Smoker ☐Current Some Day(s) Smoker

If Former Smoker, when did you quit? _____ How many packs/day did you smoke_____

If Current Smoker, how long have you smoked? _____ How many packs/day?_____

❖**Alcohol**: ☐Never ☐Rare ☐Social (how much?_____) ☐Alcoholic ☐Recovering Alcoholic

❖**Drug abuse**: ☐Never ☐Currently ☐In the past

❖**Caffeine Drinks**: ☐Yes ☐None Drinks Per Day: _____

❖**Exercise**: ☐None ☐Light ☐Moderate ☐Heavy _____ hours per week

❖**Water Intake:** _____ glasses per day ❖**Sleep**: _____ No. of hours per day

For Women: Are you taking Birth Control? ☐Yes ☐No

Are you nursing? ☐Yes ☐No Are you pregnant? ☐Yes ☐No if so, how many weeks? _____

Name: _____ **Date:**_____

What are your complaints? _____
_____
_____

Rate your pain with the following scale:

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

When did this condition begin? _____ Please explain what happened? _____
_____

Is your condition getting ☐worse ☐better ☐constant ☐comes and goes

Have you found anything to make it better? _____

Have you found anything that makes it worse? _____

Is your condition interfering with your: Work Sleep or Daily routine? If so, how:
_____
_____

Has this or something similar happened in the past? ☐Yes ☐No Explain:
_____
_____

Treatments have included: ☐No medications, therapy, injections, braces or casts.

- ☐ Physical therapy or exercise
- ☐ Anti-inflammatory meds: _____
- ☐ Massage
- ☐ Narcotic meds: _____
- ☐ Traction
- ☐ Braces
- ☐ Manipulation/chiropractic
- ☐ Cortisone injections, how many? _____
- ☐ Acupuncture

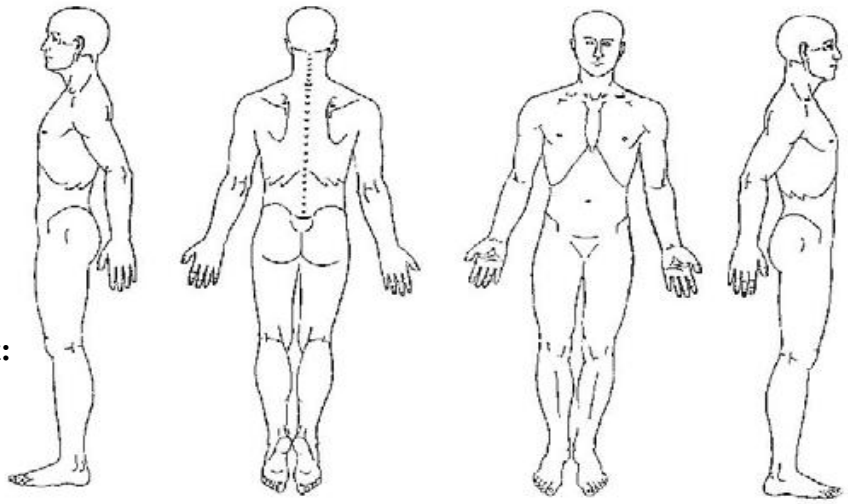
Previous doctors seen for this problem: ☐None

Doctor Specialty Date Treatments
_____
_____

Tests done to evaluate your problem: ☐None *Please list date of studies, results, and where study done if known.*

- ☐ Plain X-rays _____
- ☐ MRI/CT_____
- ☐ EMG/NCV _____
- ☐ Bone scan _____
- ☐ Other tests _____

Please circle all affected areas on the body chart:



Back In Balance Chiropractic, LLC | Brock Falconer, D.C.

INFORMED CONSENT TO TREATMENT

The Nature of Chiropractic Treatment: The doctor will use his/ her hands or a mechanical device in order to move your joints. You may feel a "click" or a "pop", and you may feel movement of the joint. Various ancillary procedures such as hot or cold packs, massage, electrical muscle stimulation, ultrasound, traction or therapeutic activities may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bones, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be reduced by screening procedures. The probability of adverse reaction to ancillary procedures is also considered "rare."

Acupuncture: Acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting.

Other Treatment Options Which Could Be Considered May Include the Following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds the risks of exposure to virulent communicable diseases in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the explanation above of chiropractic treatment and I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date