|  |  |
| --- | --- |
| chiro_logo.eps | Kim Miller Beard, DC  517-668-6215 phone  517-668-6385 fax  13105 Schavey Road  DeWitt, MI 48820  [www.balanceyourlifechiropractic.com](http://www.balanceyourlifechiropractic.com)  [info@balanceyourlifechiropractic.com](mailto:info@balanceyourlifechiropractic.com) |

Personal Information

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: | |  | | | | | | | | | | | Last Name: | | |  | | | | | | | Middle Initial: | | | |  | |
| Address: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City/State/Zip: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: | | | | ( ) | | |  | | | | | | | | | Work Phone: | | | ( ) |  | | | | | | | | |
| Mobile Phone: | | | | | ( ) | | |  | | | | | | | | Email: |  | | | | | | | | | | | |
| Social Security #: | | | | | |  | | | | | | | | | | Birth Date: | |  | | | Age: |  | | | Sex: | * M | | * F |
| Occupation: | | |  | | | | | | | | | | | | | Employer’s Name: | | | |  | | | | | | | | |
| Work Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| City/State/Zip: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Marital Status: | | | | | * S | | * M | | | * D | * W | Spouse’s Name: | |  | | | | | | | | | | # of Children: | | |  | |
| Children’s Information: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| How were you referred to Balance Your Life Chiropractic: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |

Emergency Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: |  | | | | | Relation: | |  | |
| Home Phone: | | | ( ) |  | Work Phone: | | ( ) | |  |
| Address: | |  | | | | | | | |

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ­chiro_doc_image_front.jpg | chiro_doc_image_back.jpg |  | Pain Index | | | |
|  | **D** | |  | Dull Nagging Ache |
|  | **B** | |  | Burning |
|  | **S** | |  | Sharp/Stabbing |
|  | **N** | |  | Numbness/Tingling |
| chiro_doc_image_small.jpg | | For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh. | | |

Major Complaint Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What is your major complaint? |  | | | |
| When did this symptom(s) begin? | |  | | |
| Describe what happened/how it happened: | | |  | |
| What is the pain interfering with the most in your life? | | | |  |
|  | | | | |

Severity

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| On a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain imaginable, use the key to the right to rate the severity of your pain. | | | | | | | | | | | | Key | | | |
|  | **0** = | None | |
| Sitting here today, right now, what is the intensity of your pain on a scale of 1-10? (Please circle) | | | | | | | | | | | |  | **1** = | Minimal | |
| 0 1 2 3 4 5 6 7 8 9 10 | | | | | | | | | | | |  | **2** = | Very Mild | |
| What is the least intense the symptom has been on a scale of 0-10? | | | | | | | | | | | |  | **3** = | Mild | |
| 0 1 2 3 4 5 6 7 8 9 10 | | | | | | | | | | | |  | **4** = | Mild to Moderate | |
| What is the most intense the symptom has been on a scale of 0-10? | | | | | | | | | | | |  | **5** = | Moderate | |
| 0 1 2 3 4 5 6 7 8 9 10 | | | | | | | | | | | |  | **6** = | Moderate to Severe | |
| Have you experienced these symptoms before? | | | | | | | |  | | | | | **7** = | Moderately Severe,  Restricts some activity | |
|  | | | | | | | | | | | | |
| When? |  | | | | | | | | | | | | **8** = | Severe,Limits most activity | |
|  | | | | | | | | | | | | |
| What aggravates this condition? | | | |  | | | | | | | | | **9** = | Very Severe | |
| What decreases the symptoms/pain? | | | | |  | | | | | | | | **10** = | Excrutiating | |
| Have you seen another doctor for this condition? | | | | | | | | |  | | | | | | |
| Date consulted: | |  | Diagnosis: | | |  | | | | | | | | | |
| Does this condition interfere with your sleep? | | | | | | | * Yes | | | * No | If so, how many times do you wake up in pain per night? | | | |  |

Check those activities below during which you experience difficulty or pain:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * Lying on back | * Getting in/out of car | * Pulling | * Sitting | * Standing for long periods | |
| * Lying on side | * Dressing Self | * Reaching | * Bending forward | * Sneezing | |
| * Turning over in bed | * Sexual Activity | * Kneeling | * Bending backward | * Coughing | |
| * Lying flat on stomach | * Pushing | * Stooping | * Walking | * Other: |  |

Additional Complaints

Please check all additional complaints that you have at this time:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| * Loss of Concentration | | | | | | * Neck Stiffness | | | | | | | | | | * Shortness of Breath | | | | | | | | | * Cold Hands | | | | | | | | | * Heart Disease | | | | |
| * Eyes Sensitive to Light | | | | | | * Neck Motion Restricted | | | | | | | | | | * Irritable | | | | | | | | | * Cold Feet | | | | | | | | | * Arthritis | | | | |
| * Memory Loss | | | | | | * Upper Back Pain/Stiffness | | | | | | | | | | * Anxiety | | | | | | | | | * Jaw Pain | | | | | | | | | * (HIV) Aids | | | | |
| * Heaving Feeling of Head | | | | | | * Mild Back Pain/Stiffness | | | | | | | | | | * Depression | | | | | | | | | * Hypertension | | | | | | | | | * Other (Please List) | | | | |
| * Dizziness | | | | | | * Right/Left Shoulder Pain | | | | | | | | | | * Insomnia | | | | | | | | | * Diabetes | | | | | | | | |  | | | | |
| * Ringing in Ears | | | | | | * Right/Left Arm Pain | | | | | | | | | | * Fatigue | | | | | | | | | * Convulsions | | | | | | | | |  | | | | |
| * Loss of Balance | | | | | | * Pins & Needles Arms/Legs | | | | | | | | | | * Excess Perspiration | | | | | | | | | * Allergies (Please List) | | | | | | | | | Please Specify Location: | | | | |
| * Loss of Smell | | | | | | * Right/Left Leg Pain | | | | | | | | | | * Digestive Trouble | | | | | | | | |  | | | | | | | | | * Numbness | | |  | |
| * Loss of Taste | | | | | | * Low Back Pain/Stiffness | | | | | | | | | | * Nausea | | | | | | | | |  | | | | | | | | | * Swelling | | |  | |
| * Pain Behind Ears | | | | | | * Sinus Trouble | | | | | | | | | | * Vomiting | | | | | | | | |  | | | | | | | | | * Cuts | | |  | |
| * Fainting | | | | | | * Nervousness | | | | | | | | | | * Diarrhea | | | | | | | | | * Vision Problems | | | | | | | | | * Bruising | | |  | |
| * Palpitation | | | | | | * Chest Pain | | | | | | | | | | * Constipation | | | | | | | | | * Anemia | | | | | | | | | ­ | | |  | |
| Do you have, or have you ever had, any diseases or medical problems not listed? | | | | | | | | | | | | | | | | | | | | | | | | | | * Yes | | * No | | | If so, please list: | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever had? | | | * Motor Vehicle Injury | | | | | | | | | * Sports Injury | | | | | | | | * Slip and Fall Injury | | | | | | |  | | | | | | | | | | | |
| If yes, please explain: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is there any additional information you would like the doctor to know about before beginning care? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical History | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If female, are you pregnant? | | | | | | * Yes | | | | | | | | * No | | | | | | | | | | | * Not Sure | | | | | | | | Please list date of last menstrual cycle: | | | | | |
| List all medication you are taking now, including over the counter medication. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you allergic to any medications? | | | | | | | | * Yes | | | | * No | | * Not Sure | | | | | | | Please list: | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | |  | | |  | | |  | | | | | | | | | | | | |
| Have you ever had any surgeries or hospitalizations? | | | | | | | | | | | | | | | * Yes | | | | | * No | | | Please list: | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Hospitalization/Surgery: | | | | | | | | | |  | | Date: | | | | | |  | | Type of Hospitalization/Surgery: | | | | | | | | | | | | | |  | | Date: | | |
|  | | | | | | | | | |  | |  | | | | | |  | |  | | | | | | | | | | | | | |  | |  | | |
|  | | | | | | | | | |  | |  | | | | | |  | |  | | | | | | | | | | | | | |  | |  | | |
| Have you been x-rayed or received and MRI, CAT scan in the last 12-18 months? | | | | | | | | | | | | | | | | | | | | | | | | | | * Yes | | * No | | When? | | | |  | | | | |
| Have you ever been seen by a chiropractor before? | | | | | | | | | | | | | | * Yes | | | | * No | | | | Please list: | | | | | | | | | | | | | | | | |
| Name of Chiropractor: | | | | | | | | | |  | | Dates: | | | | | |  | | Name of Chiropractor: | | | | | | | | | | | | | |  | | Dates: | | |
|  | | | | | | | | | |  | |  | | | | | |  | |  | | | | | | | | | | | | | |  | |  | | |
| Do you have a family physician? | | | | | | | * Yes | | | * No | | Name of physician: | | | | | | | | | |  | | | | | | | Phone: | | | | |  | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Office Policy

1. Records are the property of our office. Copies are only given with written permission and appropriate copying fees apply.
2. If you do not understand the procedures in your course of care, please ask. If you don’t ask, we assume you understand and consent to treatment.
3. Insurance policies are an arrangement between you and your insurance company, NOT between the insurance company and this office. You are ultimately responsible for any balance at this office.
4. Co-pays/deductibles are due at the time of service. Non-covered services are due upon billing.
5. We have a $25 No Call No Show fee (Medicaid is exempt from this)
6. Those without insurance are obligated to pay the full price of services at the time of service.
7. We accept MC/Visa/Discover.

I authorize the release of information necessary to process my health insurance claims. \_\_\_\_\_\_\_\_\_\_

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consent for Purposes of Treatment Payment and Healthcare Operations**

I acknowledge that Balance Your Life Chiropractic’s “Notice of Privacy Practices” can be provided to me.

I understand I have the right to review Balance Your Life Chiropractic’s Notice of Privacy Practices prior to signing the 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 bills or in the performance of the health care operations at Balance Your Life Chiropractic. The main administration desk can provide the Notice of Privacy Practices upon request. This Notice of Privacy Practices also describes my rights and Balance Your Life Chiropractic’s duties with request to my protected health information.

Balance Your Life Chiropractic reserves the right to change the privacy practiced that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Balance Your Life Chiropractic’s website (if applicable).

I have the right to revoke this consent, in writing, except to the extent the Balance Your Life Chiropractic has acted in reliance of the consent.

**Patient Acknowledgement**

By subscribing my name below, I acknowledge receipt of the copy of this notice and understand and my agreement to its terms.

Signature of the Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of the Personal Representative’s Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_