BACK TO HEALTH CHIROPRACTIC & MASSAGE

Appointment Time and Date: _____

WELCOME

Please fill out this form as completely as possible, the better you communicate, the better we can help you.

Patient Information

Last Name: _____
First Name: _____
Last 4 Digits of Social Security #: -_____
Gender: ❑ Female ❑ Male
Birthdate: _____/_____/_____ Age: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____

Would you like appointment reminders via text?
❑ Yes ❑ No

Phone Carrier: _____

Disclaimer: Standard text messaging rates may apply. We use the information for appointment reminders only. Please let the Front Desk know if you no longer wish to receive text appointment reminders.

Email: _____
Would you like to subscribe to our monthly Newsletter? ❑ Yes ❑ No
Occupation: _____
Employer: _____
How did you hear about us?
❑ Friend /Family (Name)
_____
❑ Internet (Google, Yahoo, Bing, etc.)
❑ Walk in/Sign
❑ Other _____
Other family members seen by us:
_____

"Health is a journey, not a destination.
This is the first step.
Maximize your potential!"

In the event of an emergency, is there someone who we should contact?
Name:_____
Relation: _____
Primary Phone: (_____) _____-_____

Family Information

Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
Spouse Name: _____
Do you have children? ❑ Yes ❑ No
How many? _____
Names and ages: _____
_____
_____

Insurance Information

Primary Insurance:

Primary Insurance Holder's:
Insurance Company: _____
Insurance Address: _____
City: _____ State: _____
Zip Code: _____
Insurance Phone #: (____) _____-_____
Policy/ID #: _____
Group #: _____

Secondary Insurance:

Do you have secondary insurance/coverage?
❑ Yes ❑ No
Insurance Company: _____
Policy/ID #: _____

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Your Current Condition

*If you have any conditions that you would like to discuss privately with the doctor, please feel free to do so during the exam.

What is the main complaint you are currently experiencing? _____
_____
_____

Do you have neck pain? ❑Yes ❑No
Describe your neck pain:
_____
_____
How often do you experience neck pain?
_____
When did the neck pain begin? _____
What caused the neck pain? ❑ Unsure
❑Other_____

Do you have middle back pain? ❑Yes ❑No
Describe your middle back pain:
_____
_____
How often do you experience middle back pain?
_____
Does the middle back pain cause:
❑Shortness of breath ❑Difficulty breathing ❑Pain with breathing
When did the middle back pain begin?_____
What caused the middle back pain? ❑ Unsure
❑Other_____

Do you have low back pain? ❑Yes ❑No
Describe your low back pain:
_____
_____
How often do you experience low back pain?
_____
When did the low back pain begin? _____
What caused the low back pain? ❑ Unsure
❑Other_____

Do you have headaches? ❑Yes ❑No
Are you sensitive to? ❑Light and/or ❑Sound
Do you experience? (Check all that apply)
❑ Dizziness ❑ Nausea ❑ Vomiting
How often do you experience headaches?
_____
When did the headaches begin? _____
What caused the headaches? ❑ Unsure
❑Other_____

Do you have numbness and/or tingling in your…? (Check all that apply)
❑ Arms ❑ Hands ❑ Legs ❑ Feet
How often do you experience numbness and/or tingling?_____
When did the numbness/tingling begin? _____
What caused the numbness/tingling? ❑ Unsure
❑Other_____

History

Did you have a previous chiropractor? ❑Yes ❑No
Name: _____
Office Name: _____
Date of last visit: _____/_____/_____
Reason for seeing: _____

Do you have a personal medical doctor? ❑Yes ❑No
M.D.'s Name: _____
Office Name: _____
Date of last visit: _____/_____/_____

Your current physical health is:
❑ Good ❑ Fair ❑ Poor

Are you currently using any prescription or over the counter drugs? ❑Yes ❑No
Please list each one: _____
_____
_____
_____

BACK TO HEALTH CHIROPRACTIC & MASSAGE

Have you had any major surgeries? ❑Yes ❑No
Please list the major surgeries and their dates:
_____
_____
_____

Have you had any serious health conditions?
❑Yes ❑No
Please list all serious health conditions and the dates:
_____
_____
_____

Do you smoke cigarettes? ❑Yes ❑No
❑Current ❑Past How Long?_____
Do you drink alcohol? ❑Yes ❑No
Do/did you have a substance or alcohol abuse problem? ❑Current ❑Past How Long?_____
Have you used anabolic steroids? ❑Yes ❑No
Have you had steroid treatment? ❑Yes ❑No

Have you had any of the following problems?

Abdominal Cramps	❑No	❑Past	❑Current
Allergies	❑No	❑Past	❑Current
Anemia	❑No	❑Past	❑Current
Ankle Swelling	❑No	❑Past	❑Current
Appetite Problems	❑No	❑Past	❑Current
Artificial Bones/Joints	❑No	❑Past	❑Current
Arthritis	❑No	❑Past	❑Current
Asthma	❑No	❑Past	❑Current
Cancer	❑No	❑Past	❑Current
Chemotherapy	❑No	❑Past	❑Current
Constipation	❑No	❑Past	❑Current
Diabetes	❑No	❑Past	❑Current
Difficulty Swallowing	❑No	❑Past	❑Current
Diarrhea	❑No	❑Past	❑Current
Discolored Urine	❑No	❑Past	❑Current
Dizziness	❑No	❑Past	❑Current
Ear Aches	❑No	❑Past	❑Current
Emphysema	❑No	❑Past	❑Current
Epilepsy	❑No	❑Past	❑Current
Excessive Thirst	❑No	❑Past	❑Current
Fainting	❑No	❑Past	❑Current
Heart Problems	❑No	❑Past	❑Current
Hemophilia	❑No	❑Past	❑Current
Hepatitis	❑No	❑Past	❑Current
High Blood Pressure	❑No	❑Past	❑Current
Intestinal Problems	❑No	❑Past	❑Current
Kidney Problems	❑No	❑Past	❑Current
Liver Problems	❑No	❑Past	❑Current
Low Blood Pressure	❑No	❑Past	❑Current
Lung Problems	❑No	❑Past	❑Current
Menstrual Dysfunction	❑No	❑Past	❑Current
Nausea/Vomiting	❑No	❑Past	❑Current
Osteoporosis	❑No	❑Past	❑Current
Pain with Urination	❑No	❑Past	❑Current
Psychiatric Problems	❑No	❑Past	❑Current
Radiation Treatment	❑No	❑Past	❑Current
Rheumatic Fever	❑No	❑Past	❑Current
Scarlet Fever	❑No	❑Past	❑Current
Seizures	❑No	❑Past	❑Current
Shingles	❑No	❑Past	❑Current
Sinus Problems	❑No	❑Past	❑Current
Stomach Problems	❑No	❑Past	❑Current
Stroke	❑No	❑Past	❑Current
Tuberculosis	❑No	❑Past	❑Current
Vision Problems	❑No	❑Past	❑Current

Are you pregnant? ❑Yes ❑No

When was the first day of your last menstrual cycle?
_____/_____/_____

****The above information is true to the best of my knowledge. I accept and acknowledge responsibility for all charges that I incur at this office. All fees are payable at the time services are rendered. I hereby authorize Back to Health Chiropractic Clinic to release my insurance carrier information required for my claim.**

Signature: X_____
Date Signed: _____/_____/_____

BACK TO HEALTH CHIROPRACTIC & MASSAGE

Informed Consent for Chiropractic Care

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 "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. A chiropractic adjustment is the specific application of forces to correct and/or reduce vertebral subluxation.

Probability of risk occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in a million to one in twenty million, and can be even further reduced by screening procedures.

Possible risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to the intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I have fully evaluated the risks and benefits of undergoing treatment. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility. I have freely decided to undergo the recommended treatment, and hereby give my fully consent to treatment.

_____	_____	_____
Print Name	Signature	Date

***X-ray/Pregnancy Release:**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. If at any point during my treatment with this office I become pregnant I fully understand that it is imperative that I notify the doctor immediately.
This office and the treating doctor take no responsibility for not being informed of a pregnancy.
Date of Last Menstrual Cycle: _____/_____/_____

Signature: X_____ Date: _____/_____/_____

Consent to Evaluate and Adjust a Minor Child:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Signature: X_____ Date: _____/_____/_____

YOUR FINANCIAL POLICY AGREEMENT WITH:

BACK TO HEALTH CHIROPRACTIC CLINIC

HEALTH INSURANCE (Major Medical Coverage): Once insurance coverage is verified, as a courtesy we will be glad to bill your insurance company for you as. You will be required to pay the amount not covered by your insurance company at each office visit.

- **BENEFIT QUOTES**: Benefit quotes from your insurance company are not a guarantee of payment, nor approval of treatment. They are solely to obtain general benefit & eligibility information as a guideline for payment.
- **INSURANCE DEDUCTIBLE**: If you have a deductible, it is your responsibility to pay for any portion that your insurance company does not cover until you have met your deductible requirements.
- **MASSAGE THERAPY**: All deductibles, co-pays and co-insurance apply and are expected at the time of treatment. Please note our massage therapists are in a very limited number of insurance networks and your insurance may not cover the massage without a diagnosis or referral from a physician.

MEDICARE: Please be advised that Medicare B will only pay for manipulations of the spine and there is a 20% co-insurance that is subject to the annual deductible first. ****MEDICARE WILL NOT PAY FOR EXAMS, X-RAYS, OR MASSAGE****

PRIVATE PAY: If you do not have health insurance, you will be responsible for all health care expenses incurred during treatment. It is your responsibility to keep your account current and make payment arrangements that are suitable for all parties.

PERSONAL INJURY PROTECTION AND AUTO ACCIDENTS: Cases will be billed directly to the insurance company, providing the appropriate paper work has been filled out correctly and the claim has been filed.

- If someone else is responsible for the auto accident, you must still notify your auto insurance so that they are aware of an accident & can provide you with a claim number for your medical bills to be paid. This is a standard procedure with auto insurance companies; your insurance company will pay your medical bills upfront (if you have personal injury coverage) and will be reimbursed from the at-fault party's insurance company when your claim is settled.
- Even if the at-fault party's insurance agrees to pay for your medical bills, they have no obligation to pay them, and may exercise this right, **leaving you fully responsible for your medical bills.**

WORKERS COMPENSATION: Workers compensation claims will be billed directly to the insurance company provided the paperwork has been filled our correctly and claim has been filed. Massage benefits are limited by Department of L&I. ****IF YOU ARE DENIED WORKERS COMPENSATION, YOU WILL BE HELD RESPONSIBLE FOR ALL BILLS INCURRED. ****

ALL PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED

I have read, agree and understand the above financial policy:

SIGNATURE: X_____ **DATE**: _____