Welcome to Back In Line Chiropractic Spine and Injury

IN ORDER TO SERVE YOU BEST WE WOULD LIKE TO KNOW MORE ABOUT YOU AND YOUR HEALTH HISTORY. PLEASE PRINT CLEARLY AND FILL IN COMPLETELY PRIOR TO YOUR APPOINTMENT TIME.

Patient Information:

Last______________________________ First____________________________ Middle________________

Please Circle Title: Mr. Mrs. Ms. Miss Dr. Rev. Suffix: Jr. Sr. III IV

Street Adress____ Apt. _____________

City_______________________________ State_________ Zip_____________ County__________________

DOB______/______/______ Age______ SSN_______-_______-_______ DL#______________________

Home Phone_________________________________ Cell Phone__________________________________

Personal Email____

Please Circle Sex: Male Female Right Handed Left Handed Married Single

Spouse's Name__________________________________ How many children do you have?_______

Children's Names & Ages____

Employment Information:

Employer Name____

Employer Address____Ste._______

City____________________________ State_________ Zip______________ How Long?_______________

Employer Phone_______________________ Ext. _________ Work Email_____________________________

Job Title_______________________________ Job Description_______________________________

Insurance & Account Information:

Insurance Company______________________________________ Group #_________________________

Insured's Name____ ID #___________________________

Insured's SSN______________________ Insured's DOB_____/_____/_____ Secondary Insurance ◊

Person ultimately responsible for this account? You and....

Please Circle Myself ONLY Spouse Auto Insurance Worker's Comp Other:____________

Name____ Relationship_____________________

Billing Address____

City_______________________________ State__________ Zip____________ Phone__________________

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. (Please sign) ____

NAME:____

Emergency Contact Information:

Name____ Relationship______________________________

Phone___________________________________ Email____

How did you hear about us?____

Chiropractic History:

Please Circle Have you ever been to a Chiropractor before? Yes No Were you satisfied w/ dr.? Yes No

Doctor's Name: ___________________________________ Date of Last Visit:_______________________

For Women Only: ***Please Circle*** Is there a possibility of you being pregnant? Yes No

I certify that to the best of my knowledge my knowledge I am not pregnant, and the doctors and staff of BACK IN LINE CHIROPRACTIC SPINE AND INJURY have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Signature: ____ Date: ______________________

Medical/Family History

S= Self M= Mother F= Father

S	M	F		S	M	F		S	M	F	
◊	◊	◊	AIDS	◊	◊	◊	Dislocated Joints	◊	◊	◊	Ulcers
◊	◊	◊	Anemia	◊	◊	◊	Epilepsy	◊	◊	◊	Nervousness
◊	◊	◊	Arthritis	◊	◊	◊	German measles	◊	◊	◊	Numbness
◊	◊	◊	Asthma	◊	◊	◊	Headaches	◊	◊	◊	Polio
◊	◊	◊	Chest Pain	◊	◊	◊	Heart Trouble	◊	◊	◊	Poor Circulation
◊	◊	◊	Bladder Trouble	◊	◊	◊	Reproductive Issues	◊	◊	◊	Hepatitis
◊	◊	◊	Bone Fracture	◊	◊	◊	High Blood Pressure	◊	◊	◊	Rheumatic Fever
◊	◊	◊	Cancer	◊	◊	◊	HIV/ARC	◊	◊	◊	Rheumatoid Arthritis
◊	◊	◊	Chest Pain	◊	◊	◊	Kidney Disorder	◊	◊	◊	Scarlet Fever
◊	◊	◊	Concussion	◊	◊	◊	Bowel Control Loss	◊	◊	◊	Osteoporosis
◊	◊	◊	Convulsion	◊	◊	◊	Menstrual Cramps	◊	◊	◊	Sinus Trouble
◊	◊	◊	Diabetes	◊	◊	◊	Multiple Sclerosis	◊	◊	◊	Tuberculosis
◊	◊	◊	Indigestion	◊	◊	◊	Muscular dystrophy	◊	◊	◊	STD's
◊	◊	◊	ADD/ADHD	◊	◊	◊	Alzheimer's	◊	◊	◊	Cerebral Palsy
◊	◊	◊	Chicken Pox	◊	◊	◊	Crohn's/Colitis	◊	◊	◊	CVA/Stroke
◊	◊	◊	Depression	◊	◊	◊	Eczema	◊	◊	◊	Emphysema
◊	◊	◊	Eye Problems	◊	◊	◊	Fibromyalgia	◊	◊	◊	Hepatitis
◊	◊	◊	Liver Disease	◊	◊	◊	Lung Disease	◊	◊	◊	Lupus
◊	◊	◊	Parkinson's	◊	◊	◊	Pneumonia	◊	◊	◊	Psoriasis
◊	◊	◊	Scoliosis	◊	◊	◊	Shingles	◊	◊	◊	Thyroid Problems
◊	◊	◊	Vertigo	◊	◊	◊	Urinary Problems	◊	◊	◊	High Cholesterol
◊	◊	◊	Prostrate Problems	◊	◊	◊	Kidney Stones	◊	◊	◊	Gull Bladder Problems
◊	◊	◊	Allergies	◊	◊	◊	Wt Gain/ Loss	◊	◊	◊	Abdominal Pain

Name:____

Health History: Are you allergic to any medications? Yes No List:____________________________

Current Medications: List ANY/ALL medications you are currently taking.

Medication	Dosage	For What Condition?	How Long?

Current Vitamins, Herbs, etc.: List ANY/ALL non-prescription terms you are CURRENTLY taking.

Description	Dosage	For What Condition?	How Long?

Have you been treated by a physician for any health condition in the last year? Yes No

Dr.s Name:____________________________________ Condition:________________________________

Accident History: List ANY/ALL accidents you have had

Accident ***Please Circle***	Description	Date(s)
Job Auto Work Other		
Job Auto Work Other		
Job Auto Work Other		
Job Auto Work Other		

Surgical History: List ANY/ALL surgeries you have had.

Describe Surgery	Date(s)

Social History:

Do you smoke? Yes No Packs/Day:__________ Drink Alcohol? Yes No Drinks/Week:_________

Drink Coffee/Caffeine? Yes No Cups/Day:_________ High Stress Level (Physical, Mental, Spiritual)

Recreational Drugs? Yes No Were you immunized as a child? Yes No

Recreational Activities you participate(d) in:____

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

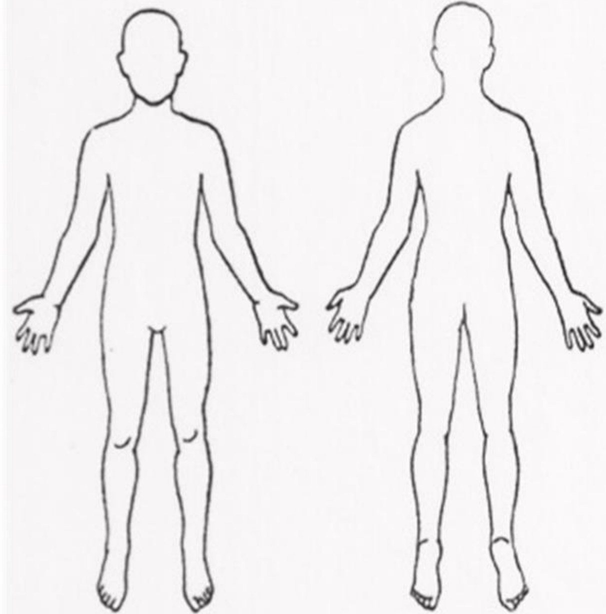
Name:____

Please Fill In Below If you have had the following, or if you suffer from the following, *Please Check*

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headaches	◊	◊
Neck Pain	◊	◊
Upper Back Pain	◊	◊
Mid Back Pain	◊	◊
Low Back Pain	◊	◊
Shoulder Pain	◊	◊
Elbow/Upper Arm Pain	◊	◊
Wrist Pain	◊	◊
Hand Pain	◊	◊
Hip Pain	◊	◊
Upper Leg Pain	◊	◊
Knee Pain	◊	◊
Joint Pain/Stiffness	◊	◊
Blurred Vision	◊	◊
Buzzing In Ears	◊	◊
Cold Hands/Feet	◊	◊
Shortness of Breath	◊	◊
Cold Sweats	◊	◊
Concentration Loss	◊	◊
Confusion	◊	◊
Constipation	◊	◊
Weeping Spells	◊	◊
Diarrhea	◊	◊
Face Flushed	◊	◊
Fainting	◊	◊
Fatigue	◊	◊
Fever	◊	◊
Shortness of Breath	◊	◊
Muscle Jerking	◊	◊
Insomnia	◊	◊
Light Bothers Eyes	◊	◊
Loss of Balance	◊	◊
Stomach Upset	◊	◊

Use the letters BELOW to indicate the type & location of your sensations right now.

A=Ache B=Burning S=Stabbing P=Pins & Needles N=Numbness



Patient Condition:

Unwanted Condition (Why are you here today?):

____

When did this condition BEGIN? _____/_____/_______

Has it ever occurred before? Yes No

If yes, when? ____________________________________

Is this Condition: Auto Related Job Related

Home Injury Slip or Fall Lifting Slept Wrong

Unknown Cause Other: ________________________

Explain:____

____

____

If accident: Date of Accident? ______/______/________

Was an accident report filed? Yes No

Was an injury report filed with your employer?

Yes No

*Please give copy of the accident/injury report to the front desk

Name:____

Informed Consent to Chiropractic Care:

Patient: Please discuss any questions or concerns with the doctor and/or associates.

The Nature of the Chiropractic Adjustment

The doctor will use her hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "pop" your knuckles. You may feel a sense of movement.

The Material Risks Inherent in the Chiropractic Adjustment

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strains, and stroke. Some patients may feel some stiffness and soreness following the first few days of treatment.

The Probability of Those Risks Occurring

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement within and outside the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided, the doctor will look for risk factors and will perform tests to identify if you may be susceptible to that kind of injury if necessary. The other complications are also generally described as "rare".

Ancillary Treatment

In addition to chiropractic adjustments, you may be given physiotherapy that also have associated risks. Therapies may include heat, cryotherapy, electric stimulation, ultrasound, trigger point therapy, rehabilitation, massage and/or other modalities that are pertinent to aid in your healing process. Associated risks included but are not limited to 1st or 2nd degree burns, skin reaction or irritation, emboli, deep vein thrombosis, and/or soreness.

The Availability And Nature Of Other Treatment Options

Other treatment options for your condition may include self-administered over-the-counter analgesics and rest, medical care with prescription drugs, hospitalization, and/or surgery.

The Material Risks Inherent In Such Options And The Probability Of Such Risks Occurring Include

Overuse of over-the-counter medications produces undesirable side effects. If complete rest and impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his/her pain tolerance, and self-discipline to not abusing the medicine. Professional literature describes highly undesirable effects from long-term use of over-the-counter medications

Prescription muscle relaxants and painkillers can produce undesirable effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort; his/her pain tolerance, self-discipline in not abusing the medicine, and proper professional supervision.

Hospitalization in conjunction with other care bears the additional risks of exposure to communicable disease, iatrogenic (doctor induced) mishap, and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic mishap, all those of hospitalization, and an extended convalescent period. The probability of those occurring varies according to many factors.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

I have read the above explanation of the chiropractic adjustment and related treatment. I understand if I have any questions I am able to ask the doctors and their associated. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. I acknowledge that no guarantee or assurance as to the results that may be obtained from this treatment has been given.

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physiotherapy/modalities and diagnostic x-rays on me (or the named minor in which I am legally responsible for) by the doctor, her staff and/or her associates.

Patient Signature:____________________________________ Date:________________

Name:____

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, ________________________________have read and fully understand the above statements. I understand if I have any questions I am able to ask the doctors, their associates and staff. I, therefore, accept chiropractic care on this basis.

Patient Signature:____Date:__________________

Payment Agreement

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to BACK IN LINE CHIROPRACTIC SPINE AND INJURY will be credited to my account upon receipt. However, I clearly understand that if I rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I also understand that if I accumulate an account balance I am responsible for paying it in full within 30 days, otherwise my account will be charged a $15 late fee and this balance will be subject to a 20% interest rate until the balance is brought to $0. Returned checks are subject to a fee of $25. If any balance goes more tan 60 days overdue, the credit card I have on file will be charged the remaining balance. Please be aware that YOU are still responsible for your bill even if you file and get judgement for any type of bankruptcy, chapter 7, chapter 13, etc.

Patient Signature:____ Date:__________________

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information. A complete copy of this document is available upon request.

Patient Signature____ Date__________________

- I give permission to use my photo in the office as witness and celebration of my wellness.
- I give permission for my name to be recorded as a means for me to be called to my adjustment.
- I give permission to use my name in the office if I refer a new member to the practice.
- I understand that if I am chosen as Patient of the Week, I give permission for certain information about my case to be disclosed in the office.
- If I choose to give a testimonial of my experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

Patient Signature____ Date__________________

Name:____

Office Policies

Cancellation of Appointment Time:

Appointment times are set for you and if you do not show up for your appointment others will miss out. If you need to cancel your appointment, please give 24 hours notice of cancellation or you will be charged a $25 cancellation fee. Initial________________________

Minor Children:

An adult must accompany all children under the age of 12 at all times while in the office. Children are not allowed to touch equipment, playing with televisions, climb on equipment, or walls, etc. Any damages arising from children touching equipment, climbing on equipment, playing with, pulling on, hitting, throwing, grabbing, etc. will be the responsibility of the parent. Parents will also be responsible for minor children that enter the lavatory and put items down the drains that clog or are mischievous or destructive in any way. Minors under the age of 18 must have a legal guardian present during all treatments. Initial________________________

Food & Drink:

There is to be no food or drinks brought into the office. Initial________________________

Cell Phones:

There is to be no cell phone use while in the office. Cell phones are disruptive and interfere with some frequencies of equipment we currently use in the office. We thank you in advance for your understanding and cooperation. Initial________________________

Therapies:

Patients are often put on therapies to assist in their health progress. Please refrain from touching the equipment or moving around while treating. Some adverse reactions can occur. This is for your safety and for the safety of the equipment. Any damages arising from touching, pulling on equipment, or other actions will be your responsibility. Initial________________________

CA: I have reviewed these policies with the patient. Initial:______________________

DR: I have reviewed these policies with the patient. Initial:______________________