Intake Forms

Welcome to our office

The purpose of this office is to help as many people as possible in their quest for optimum health and to educate them about chiropractic care so they may, in turn, educate others.

Remember how it felt to be pain-free?

Experiencing a unique type of chiropractic can be eye-opening, maybe even enough to change your perspective. How do you like to be taken care of? That is the question we ask ourselves every day. You can be sure that getting the answer right is something that drives and inspires us everyday.

Back In Balance's goal is to get you back to that place!

Back In Balance
REDMOND

First Name _____Last Name_____Date_____

Preferred or Nickname_____

Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____

Email _____

Birthday_____ Age _____Height & Weight _____

SSN _____ Referred by_____

Employer

Employer_____Occupation _____

Work Phone_____Work Email _____

Insurance

Primary Carrier_____Policy # _____

Relation to Insured:☐Self ☐Spouse Other _____

Family

Spouse's First Name_____Last Name_____

Number of kids_____ Ages _____

Chief Complaint (if any)

Reason for consulting Back In Balance:

Describe any areas of complaint or health related issues:

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE VIEW IT CAREFULLY.

In the course of your care as a patient at Back In Balance, we may use or disclose personal and health related information about you in the following ways:

Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide us with this authorization for this office to contact you regarding these matters. If you do not provide us with this authorization; it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

If we are providing health care services to you based on the orders of another health care provider.

If we provide health care services to you in an emergency.

If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

If we are ordered by the courts or other appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you should direct your complaint to the assigned HIPAA security officer in this office. This office may utilize an “open adjusting” environment for ongoing patient care. Open adjusting involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff.

This environment may be used for ongoing care and is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you.

This notice is effective as of the date listed below. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.

My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name Signature Date

If you are a minor, or if you are being represented by another party,

_____ _____ _____

Personal Representative Representative Signature Date

_____

Description of the authority to act on behalf of the patient

When a patient seeks chiropractic health care 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 corrections is by specific adjustments 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 vertebrae in the spinal column which causes alteration 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. We also do not offer advice regarding treatment prescribed by others.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctors, objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Back In Balance will gladly check your benefits based on your updated insurance card during your first office visit.

We are preferred providers with most insurance plans, including but not limited to, Premera, Premera Microsoft, United Healthcare, Aetna, Cigna and First Choice, Pacicare, Greatwest, Retail Clerks, Lifewise, Retail trust, Medicare, Labor and Industries.

Many smaller companies fall under these major companies and as stated above we will gladly check your benefits. Several companies also allow coverage out of network if that is the case.

We will happily accept car accident and work injury cases.

Cash paying patients are accepted and payment plans are available.

Regardless of individual financial circumstance, many ***no-interest payment plans*** are possible.

---------- Office Use Only ----------

Name _____ Date of Birth _____ _____ _____

Member # _____ Group # _____

Effective date _____/_____/_____ Rollover Month _____

Deductible? _____Met? _____Maximum Amount Paid _____

Co-Pay_____ % Coverage by Insurance _____

Max Visits _____ Used Visits_____

Diagnostic Coverage_____ Same as Above

PT performed by DC_____ Same as Above

No Coverage

Name_____ **Date**_____

PATIENT HISTORY

Describe in your own words the reason(s) why you are consulting Back In Balance:

When did you first notice this problem and did anything specific bring it about?

Does anything make this problem better or worse? Please describe.

Does this problem radiate or travel to another part of your body or cause any other pain or symptom?

What is the frequency of this problem and how long do the problems/symptoms last?

Family History

Is there any family history of heart disease, cancer, diabetes, depression, etc.

Social and Lifestyle History

Could you give the doctor an idea of your lifestyle and habits (ex. smoking, alcohol consumption, exercise, etc.)

Surgical, Trauma, Illness History

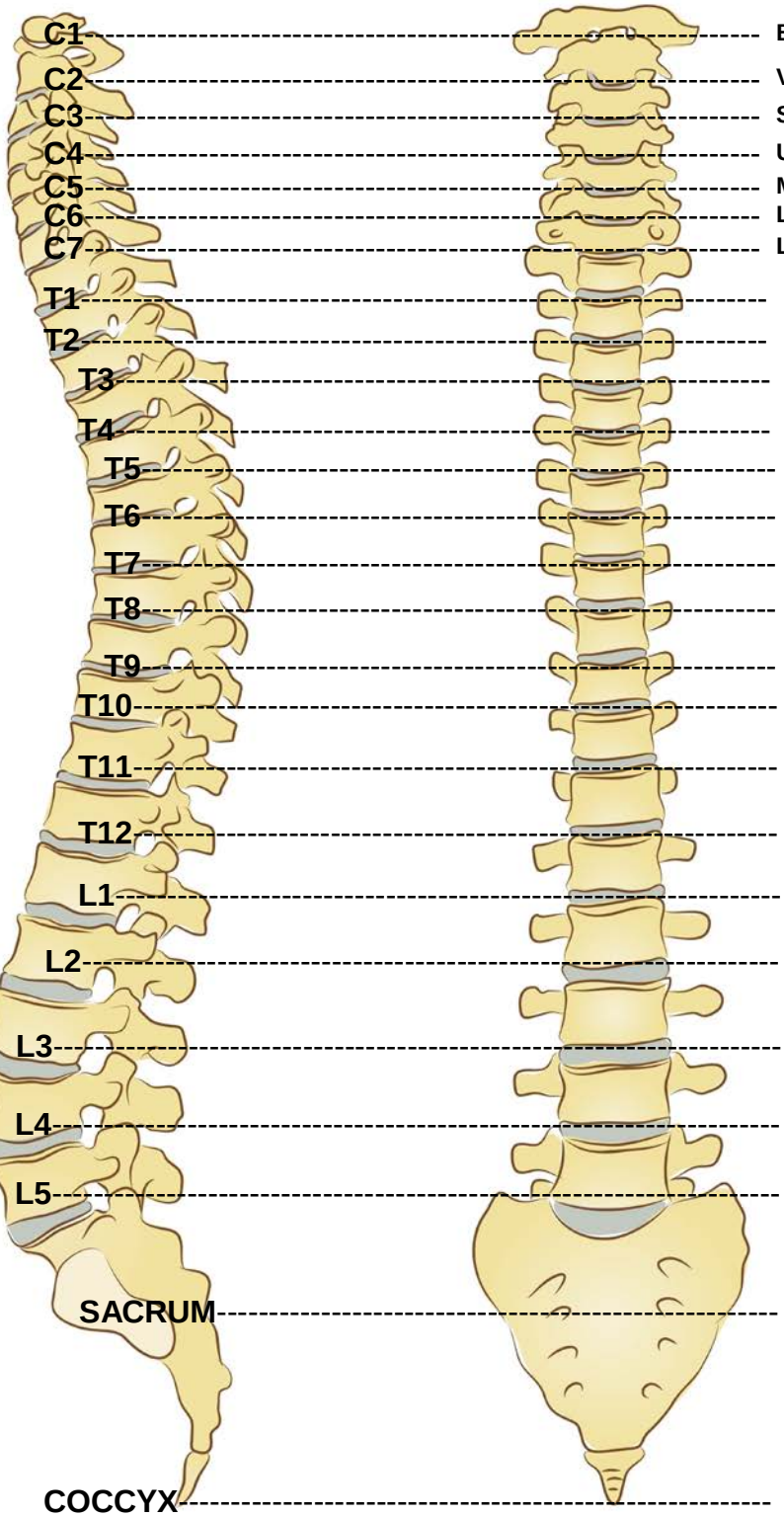
Please list any major falls, car accidents and surgery / illness

*Please note, all information collected here will be held confidential and will not be shared with any medical party unless you provide your consent.

Name_____ **Date**_____

Areas & parts of the body related to each vertebra

Please circle any symptoms you've experienced (birth to present)



	Areas & parts of the body related to each vertebra	Please circle any symptoms you've experienced (birth to present)
C1	Back of head	Headaches, migraines, tension, pulsating or throbbing discomfort
C2	Various areas of the head	**Jaw muscle or joint aches and pains**
C3	Side & front of neck	Dizziness, nervousness, vertigo
C4	Upper back of neck	
C5	Middle neck & upper arms	**Soreness, tension and tightness felt in back of neck and throat area**
C6	Lower neck, arms & elbows	
C7	Lower arms & shoulders	Pain, soreness and restriction in the shoulder area
T1	Hands, wrists, fingers, thyroid	**Bursitis, tendonitis**
T2	Heart valves & coronary arteries	Pain and soreness in arms,
T3	Lungs, bronchial tubes, pleura, chest	hands, elbows and/or fingers
T4	Gall Bladder, common duct	**Chest pains, tightness or constriction**
T5	Liver, solar plexus	Asthma,difficult breathing
T6	Stomach, mid-back	**Middle or lower mid-back pain, discomfort and soreness**
T7	Pancreas, duodenum	
T8	Spleen, lower mid-back	Various and numerous symptoms from trouble or malfunctioning of:
T9	Adrenal glands	
T10	Kidneys	**thyroid, heart, lungs, gall-bladder, liver, stomach, pancreas, spleen, adrenal glands. kidneys, small & large intestines, sex organs, uterus, bladder, prostate glands**
T11	Ureters	
T12	Small intestines, upper/lower back	
L1	Large intestines	Low back pain, aches & soreness
L2	Appendix, abdomen, upper leg	
L3	Sex organs, uterus, bladder, knees	**Trouble walking**
L4	Prostate gland, lower back	Leg, knee, ankle and foot soreness and pain
L5	Sciatic nerve, lower legs, ankles, feet	
SACRUM	Hip bones, buttocks	**Sciatica, pain or soreness in the hip and buttocks**
COCCYX	Rectum, anus	Rectal trouble

Name Date

EXAMINATION [***NAME:*** ***DATE:***]

Muscular Balance Tests

S/I Palpation	L	P	R	P
Scalenes	L	B	R	Bi
SCM	L	B	R	Bi

A/O Palpation ___|___
|

Range of Motion

Cervical

Flexion (65) ____ Pain _____ Tight ____
Extension (45) ____ Pain _____ Tight ____
Lat Rt (45) ____ Pain _____ Tight ____
Lat Lt (45) ____ Pain _____ Tight ____
Rot Rt (85) ____ Pain _____ Tight ____
Rot Lt (85) ____ Pain _____ Tight ____

Dorsolumbar

Flexion (60) ____ Pain _____ Tight ____
Extension (25) ____ Pain _____ Tight ____
Lat Rt (25) ____ Pain _____ Tight ____
Lat Lt (25) ____ Pain _____ Tight ____
Rot Rt (30) ____ Pain _____ Tight ____
Rot Lt (30) ____ Pain _____ Tight ____

Orthopedic Tests

	Left / Right
Straight leg raise	____ /____
Bragard's	____ /____
Goldthwait's	____ /____
Cerv. Comp.	____ /____
Cerv. Distr.	____ /____
Shoulder Depr.	____ /____

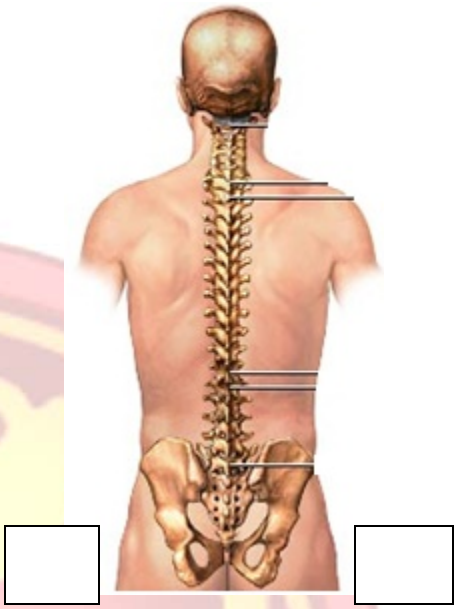
Infrared Spinal Thermography

Full Spine Cervical

Reflex Testing

	Left / Right
Biceps	____ /____
Triceps	____ /____
Patella	____ /____

Static Palpation



Bilateral Weight: **L_____ R_____**
Short Leg: **L_____ R_____ Even**
Cervical Syndrome: **L R Bil Neg**

Motion Palpation

Cervical

C1 C2 C3 C4 C5 C6 C7

Thoracic

T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12

Lumbo-Sacral-Pelvic

L1 L2 L3 L4 L5 S RtP LtP (Notes:_____)

Extremities

Scapula L R Femur L R Talus L R (Notes____)

Dermatome Testing

Light Touch	Left / Right	Sharp	Left / Right
C4	____ /____	C4	____ /____
C5	____ /____	C5	____ /____
C6	____ /____	C6	____ /____
C7	____ /____	C7	____ /____
C8	____ /____	C8	____ /____
T1	____ /____	T1	____ /____
T2	____ /____	T2	____ /____
L3	____ /____	L3	____ /____
L4	____ /____	L4	____ /____
L5	____ /____	L5	____ /____
S1	____ /____	S1	____ /____

Notes:

_____

_____