Back in Balance REDMOND

Today's Date: _____

Patient Information:

First Name: _____ Birth Date: _____ / _____ / _____ ( )
Month Day Year Age

Last Name: _____ SSN: _____ - _____ - _____

Address: _____ Sex: M ☐ F ☐ Height: _____ Weight: _____

City/Town: _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Zip Code: _____ Spouse's Name: _____

Phone: (home): _____ Number Of Children: _____

(work): _____ Preferred Contact: Home ☐ Work ☐ Cell ☐ Email ☐

(cell): _____ Employer: _____

E-Mail: _____ Job Description: _____

Health Insurance:

Primary Carrier: _____ Policy # _____

Relation to Insured: Self ☐ Spouse ☐ Other ☐

Are you here because of a car accident? Yes ☐ No ☐ Are you here because of a Work Injury? Yes ☐ No ☐

Who referred you to our office? _____

Dentist: _____ Massage Therapist: _____

Physical Therapist: _____ Other Health Provider (e.g. Naturopath): _____

Patient History:

What brings you in to consult with us today (pain, problem or concern) ?

1) _____ Onset Date? _____ / _____ *(Month/Year)*

Severity of Pain (circle one): ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***

What do you think caused this complaint? _____

What makes the problem better? _____

What makes the problem worse? _____

Does the problem radiate or travel to another part of your body? _____

What is the frequency of this problem and how does it last? _____

2) _____ Onset Date? _____ / _____ *(Month/Year)*

Severity of Pain (circle one): ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***

What do you think caused this complaint? _____

What makes the problem better? _____

What makes the problem worse? _____

Does the problem radiate or travel to another part of your body? _____

What is the frequency of this problem and how does it last? _____

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3) _____ Onset Date? _____ / _____ *(Month/Year)*

Severity of Pain (circle one): ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***

What do you think caused this complaint? _____

What makes the problem better? _____

What makes the problem worse? _____

Does the problem radiate or travel to another part of your body? _____

What is the frequency of this problem and how does it last? _____

Do you wear orthotics? Yes ❑ No ❑ Do you have/wear a dental splint? Yes ❑ No ❑

Check medications you are currently taking:

❑ Nerve pills	❑ Anti-inflammatory	❑ Supplements	❑ Other: _____
❑ Birth control	❑ Muscle relaxants	❑ Vitamins/minerals	_____
❑ Antidepressants	❑ Pain Killers	❑ Blood Pressure	_____

Supplements you are currently taking:

_____

_____

_____

For women only: Please check off the following that you experience:

❑ Congested breasts	❑ Breast lumps	❑ Menstrual pain	❑ Excessive flow
❑ Irregular cycle	❑ Hot flashes	❑ Vaginal discharge	

Social History:

How much alcohol do you drink per week? _____

How much coffee do you drink per day? _____

How much water do you drink per day? _____

Do you smoke? ❑ Yes ❑ No

Do you stretch daily? ❑ Yes ❑ No

How many times a week do you exercise? _____

What type of exercise do you do? _____

How would you rate your daily stress levels? ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***

Physical History: *(Please describe and date)*

Any Falls: _____

Any Accidents: _____

Any Broken Bones: _____

Any Surgeries: _____

Any Hospitalizations: _____

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Do you have a Diagnosed Disease(s) or Condition(s)? (e.g. Cancer, Diabetes, Epilepsy, Mental/Emotional Condition):

What Childhood Diseases(s) did you have? (e.g. Mumps, Chicken Pox, Measles, etc.):

Family History:

Do any of your immediate family (e.g. brother, mother, etc.) have a Major Health Problem(s)?

Family Member: _____ Health Problem: _____

Family Member: _____ Health Problem: _____

Family Member: _____ Health Problem: _____

Health History **-** *Please check which of the following you have had or are currently experiencing:*

Past	Current		Past	Current		Past	Current		Past	Current	
❑	❑	Abdominal discomfort	❑	❑	Cold hands	❑	❑	Throat pain	❑	❑	Prostate problems
❑	❑	Indigestion	❑	❑	Cold feet	❑	❑	Sinus pain	❑	❑	Poor bladder control
❑	❑	Nausea	❑	❑	Chest pain	❑	❑	Nose bleeds	❑	❑	Painful urination
❑	❑	Constipation	❑	❑	Rapid heart beat	❑	❑	Ear aches	❑	❑	Frequent urination
❑	❑	Bloating	❑	❑	Slow heart beat	❑	❑	Ear discharge	❑	❑	Discolored urine
❑	❑	Diarrhea	❑	❑	Irregular heart beat	❑	❑	Ear noises	❑	❑	Unexplained swelling
❑	❑	Vomiting	❑	❑	High blood pressure	❑	❑	Deafness	❑	❑	Convulsions
❑	❑	Loss of appetite	❑	❑	Low blood pressure	❑	❑	Eye pain	❑	❑	Tremors
❑	❑	Rapid weight loss	❑	❑	Dizziness	❑	❑	Vision problems	❑	❑	Rash
❑	❑	Excessive hunger	❑	❑	Bruising	❑	❑	Headaches	❑	❑	Boils on skin
❑	❑	Gall bladder problems	❑	❑	Asthma Symptoms	❑	❑	Neck pain	❑	❑	Dental decay
❑	❑	Liver problems	❑	❑	Allergies	❑	❑	Mid Back Pain	❑	❑	Hernia
❑	❑	Jaundice	❑	❑	Difficulty breathing	❑	❑	Low back pain	❑	❑	Insomnia
❑	❑	Frequent colds	❑	❑	Wheezing	❑	❑	Arm/Hand Pain	❑	❑	Fatigue
❑	❑	Chills	❑	❑	Chronic Cough	❑	❑	Leg pain	❑	❑	Tonsillitis
❑	❑	Fever	❑	❑	Spitting phlegm	❑	❑	Foot pain	❑	❑	Joint pain / stiffness
❑	❑	Sweats	❑	❑	Spitting blood	❑	❑	Numbness/tingling	❑	❑	Other: _____

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HIPPA Form

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.

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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)

Terms of Acceptance:

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 doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

_____	_____
(Signature)	*(Date)*

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