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? _____

Back In Balance Redmond - 2761 152nd Ave NE Redmond, WA 98052 Phone - (425) 437-9974 – Fax (425) 437-9964
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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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HIPAA Notice of Privacy Practices

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 REVIEW IT CAREFULLY.

Effective Date: October 24, 2026

Your Rights

When it comes to your health information, you have the right to:

- **Get a copy of your health and billing records**, on paper or electronically. Ask us in writing. We will usually provide a copy or summary within 30 days and may charge a reasonable, cost-based fee.
- **Ask us to correct your records** if you think they are incorrect or incomplete. We may say no, but we will tell you why in writing within 60 days.
- **Request confidential communications.** You can ask us to contact you a specific way (for example, cell phone or email) or to send mail to a different address. We will say yes to all reasonable requests.
- **Ask us to limit what we use or share.** We are not required to agree, with one exception: if you pay for a service out of pocket in full, you can ask us not to share information about that service with your health insurer, and we will say yes unless a law requires us to share it.
- **Get a list of those we have shared your information with** for up to six years before your request, other than for treatment, payment, health care operations and certain other disclosures. One list per year is free.
- **Get a paper copy of this notice** at any time, even if you agreed to receive it electronically.
- **Choose someone to act for you.** If someone has your medical power of attorney or is your legal guardian, they can exercise your rights.
- **File a complaint** if you feel your rights have been violated (see Questions or Complaints below).

How We Typically Use and Share Your Information

- **Treatment:** We may share your information with other health care providers caring for you, such as when we refer you for further evaluation or coordinate your care.
- **Payment:** We may use and share your information to bill and get payment from you, your health plan, or another party responsible for payment, such as an auto or workers' compensation insurer.
- **Running our practice:** We may use your information to run our office and improve your care, including contacting you about appointments by phone, text, email or voicemail.

Other Ways We May Share Your Information Without Your Permission

When the law allows or requires it, we may share your information to: help with public health and safety issues, such as reporting suspected abuse or preventing a serious threat to someone's health or safety; comply with the law, including requests from the U.S. Department of Health and Human Services; respond to lawsuits, court orders and subpoenas; work with law enforcement, health oversight agencies, coroners and medical examiners; handle workers' compensation claims; support organ donation or research; and respond to special government functions such as military or national security requests.

Uses That Require Your Written Permission

We will never use or share your information for marketing purposes, sell your information, or share psychotherapy notes without your written permission. Any other use or sharing not described in this notice also requires your written permission. You may revoke your permission in writing at any time, except where we have already acted on it.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- Where Washington State law gives your information more protection than federal law, we follow the stricter law.

Changes to This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Questions or Complaints

Privacy Officer: Dr. Justin Schallmann, DC, Back In Balance Redmond, 2761 152nd Ave NE, Redmond, WA 98052, (425) 437-9974

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices:

My signature acknowledges that I have received a copy of this office's Notice of Privacy Practices.

(Patient Name - Print)	*(Signature)*	*(Date)*
(Personal Representative, if applicable)	*(Representative Signature)*	*(Authority to act for patient)*

Office use only: Acknowledgment not obtained because: _____ Initials: _____

Terms of Acceptance

When a patient seeks chiropractic care and we accept a patient for such care, it is essential that we both work toward the same objective. It is important that each patient understands both the objective and the method we use to reach it. This prevents confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to help the body correct vertebral subluxation. Our chiropractic method of correction 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 vertebrae of the spine that may interfere with normal nerve function and the body's ability to function at its best.

Scope of our care: Our care focuses on locating and correcting vertebral subluxation through specific spinal adjustments. We do not provide treatment for disease. If during our examination we find a non-chiropractic or unusual finding, we will advise you and recommend that you see a health care provider who specializes in that area. We do not offer advice about treatment prescribed by others.

Office Policies:

- **Scheduling:** (425) 437-9974 (live answering service) or scheduling@backinbalanceredmond.com. Patients who booked online can cancel through their online booking.
- **Cancellations:** 24 hours' notice is required to cancel or reschedule an appointment. Late cancellations and no-shows are charged a $75 fee.
- **Payment:** Payment is due at the time of service unless other arrangements have been made in advance.

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)*
(Parent/Guardian Signature, if patient is under 18)	*(Date)*

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