

**New Practice Member Application**

Today's Date: \_\_\_\_\_

File #: \_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Marital Status:  Single  Married Do you have insurance?  Yes  No  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Number of children and ages: \_\_\_\_\_  
 Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

**HISTORY OF COMPLAINT**

Please identify the condition(s) that brought you to this office: Primary: \_\_\_\_\_  
 Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

**Primary** or chief complaint is:      0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10  
**Second** complaint is:                0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10  
**Third** complaint is:                    0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10  
**Fourth** complaint is:                  0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM

How long does it last?  It is constant  I experience it on and off during the day  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

**PLEASE MARK** the areas on the body diagram with the following **letters** to describe your symptoms:

**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling**

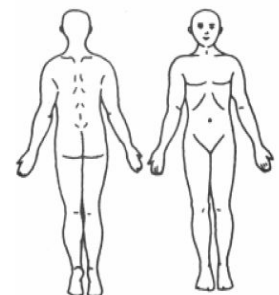
What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when? \_\_\_\_\_ by

whom? \_\_\_\_\_ Name of previous chiropractor: \_\_\_\_\_  **N/A**

How long were you under care? \_\_\_\_\_ What were the results? \_\_\_\_\_



PATIENT'S NAME: \_\_\_\_\_ File #: \_\_\_\_\_ DATE: \_\_\_\_\_

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident?  Yes  No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_

\_\_\_\_\_

### CIRCLE ALL CURRENT PROBLEMS YOU HAVE

- |                   |                 |                    |                         |                     |
|-------------------|-----------------|--------------------|-------------------------|---------------------|
| NECK PAIN         | MID BACK PAIN   | NUMBNESS IN HANDS  | NUMBNESS IN FEET        | DISC PROBLEMS       |
| HEADACHES         | LOW BACK PAIN   | NUMBNESS IN ARMS   | NUMBNESS IN LEGS        | HIP/PELVIC PAIN     |
| SCOLIOSIS         | ARMS PAIN       | TMJ/JAW PAIN       | LEG PAIN                | SCIATICA            |
| MUSCLE SPASMS     | MUSCLE WEAKNESS | KNEE PAIN          | SHOULDER PAIN           | DIZZINESS/VERTIGO   |
| NAUSEA            | SINUS ISSUES    | CHEST PAIN         | MENSTRUAL CRAMPS        | BLADDER PROBLEMS    |
| ANXIETY           | RINGING IN EARS | HEART DISORDERS    | INFERTILITY/MISCARRIAGE | PLANTAR FASCIITIS   |
| DEPRESSION        | THROAT ISSUES   | H/L BLOOD PRESSURE | KIDNEY PROBLEMS         | SHORTNESS OF BREATH |
| NERVOUSNESS       | THYROID ISSUES  | ALLERGIES          | ASTHMA                  | FREQUENT COLDS      |
| EPILEPSY/SEIZURES | EAR INFECTIONS  | CHRONIC FATIGUE    | LIVER DISEASE           | FIBROMYALGIA        |
| ADD/ADHD          | INSOMNIA        | DIGESTIVE ISSUES   | PROSTATE ISSUES         | VISION CHANGES      |
| ARTHRITIS         | ECZEMA/RASH     | ACID REFLUX/ULCERS | PERIOD IRREGULARITY     | SWELLING IN JOINTS  |
|                   |                 |                    |                         | OTHER: _____        |

### **PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes**, how many times? \_\_\_\_\_

When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state what type of treatment: \_\_\_\_\_ who provided it? \_\_\_\_\_ How long ago? \_\_\_\_\_

What were the results.  Favorable  Unfavorable

Please explain: \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

\_\_\_\_\_

**If you have ever been diagnosed with any of the following conditions, please indicate with:**

- |  |  |   |
|--|--|---|
| <b>P</b> for in the <b>Past</b>  | <b>C</b> for <b>Currently</b> have   | <b>N</b> for <b>Never</b> have had  |
| <input type="checkbox"/> Broken Bone <input type="checkbox"/> Dislocations <input type="checkbox"/> Tumors<br><input type="checkbox"/> Heart Attack <input type="checkbox"/> Osteo Arthritis <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Cerebral Vascular | <input type="checkbox"/> Fracture <input type="checkbox"/> Disability <input type="checkbox"/> Cancer<br><input type="checkbox"/> Other serious conditions: _____ |

PATIENT'S NAME: \_\_\_\_\_ File #: \_\_\_\_\_ DATE: \_\_\_\_\_

PLEASE IDENTIFY ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	ISSUE	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES				
SURGERIES				
CHILDHOOD DISEASES				
ADULT DISEASES				

### SOCIAL HISTORY

- Smoking:**  cigars  chew  cigarettes How often?  Daily  Weekends  Occasionally  Never
- Alcoholic Beverage:** consumption occurs  Daily  Weekends  Occasionally  Never
- Recreational Drug use:**  Daily  Weekends  Occasionally  Never
- Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See Activities of Life form)

### FAMILY HISTORY

- Does anyone in your family suffer with the same condition(s)?  No  Yes  
 If yes, whom?  
 grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)  
 Have they ever been treated for their condition?  No  Yes  I don't know
- Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_
- Are there any conditions that your family suffer from that you would like to see if Neurologically-Based Chiropractic Care could help with?  
 If yes whom:  grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)

Please Circle Condition:

- |                   |            |                |                     |                 |                  |
|-------------------|------------|----------------|---------------------|-----------------|------------------|
| Headaches         | Neck Pain  | Jaw/TMJ Pain   | Back Pain           | Hip/Leg Pain    | Arthritis        |
| Dizziness/Vertigo | Fatigue    | Sleep Issues   | High Blood Pressure | COPD            | Anxiety          |
| Depression        | ADHD       | Ear Infections | Sinus Issues        | Asthma          | Allergies        |
| Stomach Problems  | Bedwetting | Insomnia       | Scoliosis           | Disc Herniation | Spinal Surgeries |

I hereby authorize payment to be made directly to Balanced Life Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Balanced Life Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
 Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Date Completed

\_\_\_\_\_  
 Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Date Form Reviewed

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

**ACTIVITIES:**

**EFFECT:**

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewer

PATIENT'S NAME: \_\_\_\_\_ File #: \_\_\_\_\_ DATE: \_\_\_\_\_

### QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain \_\_\_\_\_ Worst possible pain  
0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its best? \_\_\_\_\_%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

\_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain its worst? \_\_\_\_\_%

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Score: Q1 \_\_\_\_\_ + Q2 \_\_\_\_\_ + Q3 \_\_\_\_\_ + Q4 \_\_\_\_\_ = \_\_\_\_\_ / 3 x 10 = \_\_\_\_\_ (Low Intensity = <50; High Intensity = >50)

PATIENT'S NAME: \_\_\_\_\_ File #: \_\_\_\_\_ DATE: \_\_\_\_\_

**Balanced Life Chiropractic**  
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www.balancedlifesd.com

**Dr. Harley R. Martinmaas**  
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info@balancedlifesd.com

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

#### **YOUR RIGHTS:**

1. To inspect or obtain a copy of your records, usually within 30 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

#### **USES AND DISCLOSURES:**

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

#### **COMPLAINT:**

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights  
200 Independence Avenue, SW, Washington DC 20201  
877-696-6775  
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

PATIENT'S NAME: \_\_\_\_\_ File #: \_\_\_\_\_ DATE: \_\_\_\_\_

***NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...***

Please complete the following where indicated and return to our front desk staff.

Patient initials: \_\_\_\_\_ - retaining **page 1 of 2**

I hereby acknowledge I have read and received a copy of Balanced Life Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

\_\_\_\_\_ Parent or guardian of minor patient

\_\_\_\_\_ Guardian or conservator of an incompetent patient

\_\_\_\_\_ Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

**For Office Use Only**

Signed form received by:

Reason acknowledgment not obtained:

Efforts to obtain:

PATIENT'S NAME: \_\_\_\_\_ FILE #: \_\_\_\_\_ DATE: \_\_\_\_\_

## Balanced Life Chiropractic

### Informed Consent

#### REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Balanced Life Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature      Date



Witness Initials

#### REGARDING: X-rays/Imaging Studies

**FEMALES ONLY:** *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-\_\_\_\_ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient or Authorized Person's Signature      Date



Witness Initials