Balanced Life
CHIROPRACTIC

**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 |

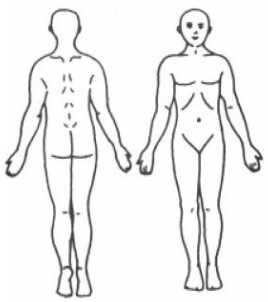
When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

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 = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



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:

**P** for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ 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** | | | | |

## PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? □ Yes □ No
If not, how many pregnancies previously? _____
How many children do you have? _____
How many vaginal deliveries? _____ How many cesarean deliveries? _____
Was labor induced using Pitocin? □ No □ Yes □ Unknown
Was there any hip or back pain during labor? □ No □ Yes
Was baby in a suboptimal position during the pushing phase of labor? □ No □ Yes □Unknown
Did you receive an epidural? □ No □ Yes
Were there any operative devices used? □ No □ Yes □ Forceps □ Vacuum
Any postpartum complications or long term consequences? □ No □ Yes _____
_____Any other details you would like to provide? _____
_____

Do you plan to follow the same plan as your previous delivery? □ No □ Yes
If not, what would you like to change? _____
_____
_____

## CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date? ___/___/_____ How many weeks are you? _____

Did you have any difficulty conceiving? □ No □ Yes
If yes, please explain:

Have you used any form of hormonal contraceptives? □ No □ Yes
If yes, which ones and how long?

Have you experienced morning sickness? □ No □ Yes
If yes, please explain:

## CURRENT HEALTH CONDITIONS

What type of exercise are you currently performing? _____
_____

Please tell us about your current diet, and any dietary restrictions: _____
_____

PATIENT'S NAME: _____ File #: _____ DATE: _____

Have you taken any medications or supplements during your pregnancy? □ No □ Yes
If yes, please explain: _____

Have you had any slips, falls or other physical traumas during this pregnancy? □ No □ Yes
If yes, please explain: _____
_____

Have you had any major emotional stressors during this pregnancy? □ No □ Yes
If yes, please explain: _____
_____

## YOUR BIRTH PLAN

What are your top 3 goals for this pregnancy?

1. _____
2. _____
3. _____

Do you currently have a birth plan? □ No □ Yes
If yes, please explain:

Are you taking any pre-natal or birthing classes? □ No □ Yes
If yes, please explain:

Who is your OBGYN or Midwife? Will he/she be present for delivery? □ No □ Yes

Who is your birth provider?

Do you intend to have a birth coach or doula present? □ No □ Yes
If yes, please explain:

Do you wish to have a medicine free labor and delivery? □ No □ Yes
Any concerns?

## YOUR POST- BIRTH PLAN

Do you plan on breastfeeding your child? □ No □ Yes

What would you like to gain from chiropractic care during your pregnancy?

Is there anything else you'd like to tell us about your pregnancy or birth plan?

Are there any burning questions you want to be sure to ask today?

PATIENT'S NAME: _____ File #: _____ DATE: _____

## SOCIAL HISTORY

**1. Smoking**: ○ cigars ○ chew ○ cigarettes How often? ○ Daily ○ Weekends ○ Occasionally ○ Never

**2. Alcoholic Beverage**: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never

**3. Recreational Drug use**: ○ Daily ○ Weekends ○ Occasionally ○ Never

**4. Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See Activities of Life form)

## FAMILY HISTORY

1. 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

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes: _____

3. 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**

PATIENT'S NAME: _____ File #: _____ DATE: _____

## 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 | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sit to Stand | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Climb Stairs | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Pet Care | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Extended Computer Use | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Lift Children/Groceries | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Read/Concentrate | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Getting Dressed | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Shaving | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sexual Activities | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sleep | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Static Sitting | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Static Standing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Yard work | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Walking | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Washing/Bathing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sweeping/Vacuuming | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Dishes | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Laundry | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Garbage | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Driving | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Other: _____ | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ 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 individuation complain 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_____=_____/3x10=_____ (Low Intensity = <50; High Intensity = >50)

PATIENT'S NAME: _____ File #: _____ DATE: _____

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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:

PATIENT'S NAME: _____ File #: _____ DATE: _____

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/

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: _____

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)

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

**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)

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

PATIENT'S NAME: _____ File #: _____ DATE: _____