



BACK TO BALANCE

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Welcome to Back to Balance Wellness Center!

Patient Information:

Thank you for choosing our practice for your health needs. Please complete the attached forms in in. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Date: _____ Sex: - Female o Male

Name: _____ D.O.B: ___/___/___ SS#: _____ - _____ - _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____ Work Phone #: _____

Where do you prefer to receive calls: (please circle) Home Work Mobile Any

Please circle which applies to you: Minor Single Married Divorced Widowed

Employer: _____ Occupation: _____

Business Address: _____
Street City State Zip

Person to contact in case of emergency? _____ Phone #: _____

Whom may we thank for referring you to us? _____

Appointment Confirmation Emails & Newsletter:

Please give us your email address for our office's confirmation list You will receive information regarding your appointments and our practice. We WILL NOT give this information out to anyone.

Email Address: _____

Symptoms:

Reason for visit: _____ Date when first appeared: _____

Is this condition worsening? (circle) YES or NO What gives you relief? _____

How often your are experiencing these symptoms? (please circle below)

Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (11-25%) Rare (0-11%)

Which activities are difficult to perform? (please circle all that apply below)

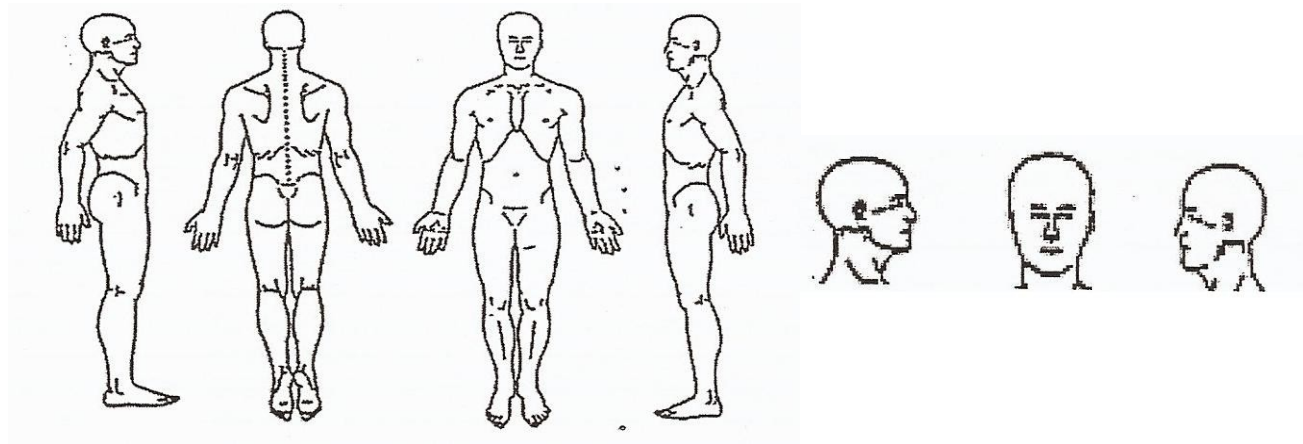
Sitting Standing Walking Bending Lying Down Other

Symptoms continued....

Type of Pain: (please circle all that apply below)

Sharp	Dull	Throbbing	Numbness	Aching	Shooting								
Burning	Tingling	Cramps	Stiffness	Swelling	Other								
Rate the severity of your pain: (1 for mild, 10 for severe pain)				1	2	3	4	5	6	7	8	9	10

Please mark your areas of pain on the figures below:



Health History

- | | | | | | |
|--|--|--|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Goiter | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypersensitivity |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arteriosclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Other: _____ | | | |

X-Ray Confirmation

This is to confirm that this office has advised me that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

Signature

Date

Daily Habits

What type of exercises do you perform on a daily basis? (circle) None Moderate Heavy

What do your daily work habits include? (circle) Sitting Standing Light Labor Heavy Labor Other

What vitamins and/or nutritional supplements do you currently take? _____

Please list any medications you are currently taking: _____

Allergies: _____

How much alcohol do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature

Date

-1 Thank you for choosing Back to Balance as a partner in your health!

Please review all of the following guidelines carefully:

1. *Be Realistic!* Always remember that improving your health largely involves how you take care of yourself outside the facility. Follow your care plan, exercises, and stretching techniques. It takes time to develop injuries and pain cycles; therefore, it takes time to correct problems. Be patient!
2. **We require a 24-hour notice for patient cancellations.** All cancellations or no shows within 24 hours will be subjected to a penalty.
3. Please note that at times your insurance carrier may change certain policies, which allows them to send payments directly to the patient rather than to Back to Balance. In most cases, the payment may be made directly to you, but it is for the coverage of the services you have received here. **As a patient, you are responsible for contacting Back to Balance as soon as you receive the payments and making sure that we receive them.**
4. Remember to turn your cell phones on vibrate upon entering the practice. Also, children under the age of 12 are not to be left in the waiting room alone. **Massages are in session at all times and we appreciate your consideration.**
5. Do **NOT** drink alcohol for 24 hours after your session. Be sure to drink plenty of water.
6. Discomfort can occur after a visit to the center. Please be patient and communicate with the staff. We are here to help you!
7. Please inform us of any paper work sent to you in regards to your health coverage so that we may review it with you.
8. If you have any changes in address, phone number, or insurance information, let us know as soon as possible. Incorrect information can cause a delay in health coverage payment or even denial of claims.
9. Back to Balance reserves the right to discontinue treatment if the patient is non-compliant with the set care plan protocols. Remember, we are here to help you and appointments not kept could be given to others.
10. Please make sure to inform us if there are any changes in your health status including **pregnancy or illnesses** as it can alter the type of treatment you are receiving.
11. At times, one of our staff members may not be present. Please be patient with us in helping to reschedule your appointments. Keep in mind we are a team and we prefer patients to keep their chiropractic appointments even if a massage is unavailable.

We greatly appreciate the referral of your friends and family. It is never too soon or too late to being treatments. We can help! *Your health is your wealth.*

Signature

Date