

Mark where your pain is

What is your chief complaint: _____

How would you rate the level of discomfort right now on a scale of 1-10, with 10 being the worst:

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? 1 2 3 4 5 6 7 8 9 10

Describe the onset of discomfort? **Gradual** or **Sudden**

When did the discomfort begin? _____

Is the condition getting: **Better** **Worse** **Same**

What aggravates the discomfort? **Bending** **Dressing** **Driving** **Exercising**

Lifting **Lying** **Sitting** **Sleeping** **Standing** **Twisting** **Walking** **Working** **Other**

What percentage worse is the discomfort after it is aggravated? _____

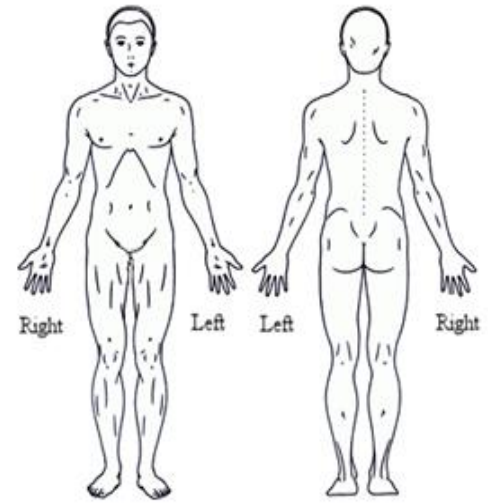
How many minutes will the discomfort remain that way? _____

Anything that relieves the discomfort? _____

What percentage would you say that the discomfort improves? _____

What is the quality of discomfort? **Aching** **Burning** **Deep** **Dull** **Numb**
Sharp **Shooting** **Tingling** **Tightness** **Other** _____

When is the discomfort at its worst? **Morning** **Afternoon** **Evening**



Second complaint: _____

How would you rate the level of discomfort right now on a scale of 1-10, with 10 being the worst:

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? 1 2 3 4 5 6 7 8 9 10

Describe the onset of discomfort? **Gradual** or **Sudden**

When did the discomfort begin? _____

Is the condition getting: **Better** **Worse** **Same**

What aggravates the discomfort? **Bending** **Dressing** **Driving** **Exercising**

Lifting **Lying** **Sitting** **Sleeping** **Standing** **Twisting** **Walking** **Working** **Other**

What percentage worse is the discomfort after it is aggravated? _____

How many minutes will the discomfort remain that way? _____

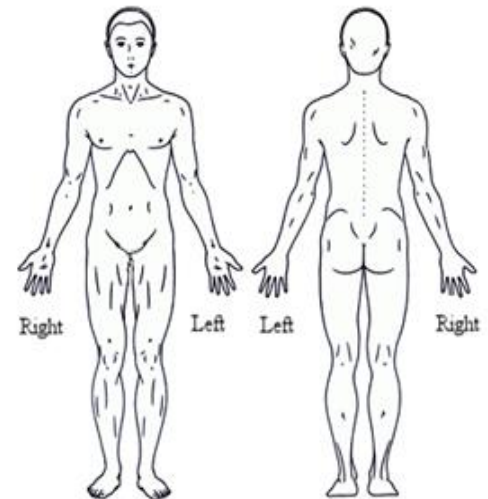
Anything that relieves the discomfort? _____

What percentage would you say that the discomfort improves? _____

What is the quality of discomfort? **Aching** **Burning** **Deep** **Dull** **Numb**
Sharp **Shooting** **Tingling** **Tightness** **Other** _____

When is the discomfort at its worst? **Morning** **Afternoon** **Evening**

Mark where your pain is



What is third complaint: _____

Mark where your pain is

How would you rate the level of discomfort right now on a scale of 1-10, with 10 being the worst:

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? 1 2 3 4 5 6 7 8 9 10

Describe the onset of discomfort? **Gradual** or **Sudden**

When did the discomfort begin? _____

Is the condition getting: **Better** **Worse** **Same**

What aggravates the discomfort? **Bending** **Dressing** **Driving** **Exercising**

Lifting **Lying** **Sitting** **Sleeping** **Standing** **Twisting** **Walking** **Working** **Other**

What percentage worse is the discomfort after it is aggravated? _____

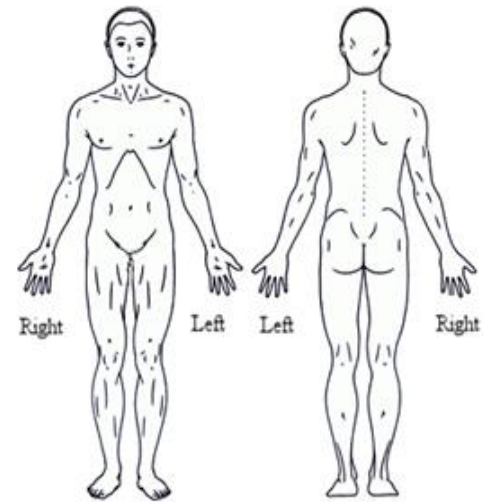
How many minutes will the discomfort remain that way? _____

Anything that relieves the discomfort? _____

What percentage would you say that the discomfort improves? _____

What is the quality of discomfort? **Aching** **Burning** **Deep** **Dull** **Numb**
Sharp **Shooting** **Tingling** **Tightness** **Other** _____

When is the discomfort at its worst? **Morning** **Afternoon** **Evening**



What is your fourth complaint: _____

Mark where your pain is

How would you rate the level of discomfort right now on a scale of 1-10, with 10 being the worst:

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? 1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? 1 2 3 4 5 6 7 8 9 10

Describe the onset of discomfort? **Gradual** or **Sudden**

When did the discomfort begin? _____

Is the condition getting: **Better** **Worse** **Same**

What aggravates the discomfort? **Bending** **Dressing** **Driving** **Exercising**

Lifting **Lying** **Sitting** **Sleeping** **Standing** **Twisting** **Walking** **Working** **Other**

What percentage worse is the discomfort after it is aggravated? _____

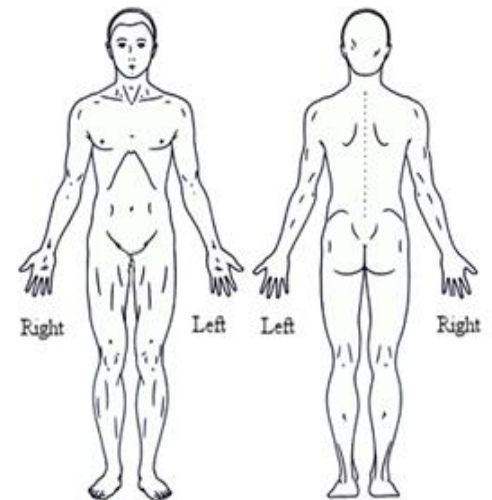
How many minutes will the discomfort remain that way? _____

Anything that relieves the discomfort? _____

What percentage would you say that the discomfort improves? _____

What is the quality of discomfort? **Aching** **Burning** **Deep** **Dull** **Numb**
Sharp **Shooting** **Tingling** **Tightness** **Other** _____

When is the discomfort at its worst? **Morning** **Afternoon** **Evening**



Review of Systems

Please mark each item below for each sign or symptom you currently have or previously had:

Mark "C" for current Mark "P" for past

CONSTITUTIONAL

- Weight Loss
- Weight Gain
- Decrease Energy
- Increase Energy
- Difficulty Sleeping

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Osteoporosis
- Joint Replacement
- Herniated Disc
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Muscle Weakness
- Sprains/Strains
- Broken Bones
- Gout
- Fibromyalgia
- Arthritis

GENITOURINARY

- Blood in Urine
- Frequent Urination
- Kidney Disease
- Painful Urination
- Kidney Stone
- Loss of Bladder Control
- STD

CARDIOVASCULAR

- High Blood Pressure
- Heart Attack
- Chest Pain
- Poor Circulation
- Heart Disease
- Irregular Heartbeat
- Jaw pain
- Aortic Aneurism
- Swelling Ankles
- Varicose Veins
- High Cholesterol
- Pacemaker/Defibrillator

EAR/EYE/NOSE/THROAT

- Ear Noises
- Dizziness
- Sore Throat
- Hearing Loss
- Nasal Blockage
- Nose Bleeds
- Glaucoma
- Sinusitis
- Difficulty Swallowing
- Bleeding Gums
- Double Vision
- Blurred Vision

INTEGUMENTARY

- Skin Ulcers
- Skin Disease
- Eczema
- Psoriasis
- Rashes
- Dryness
- Sensitive Skin
- Boils

GASTRO-INTESTINAL

- Bowel Problems
- Constipation
- Diarrhea
- Hemorrhoids
- Gallbladder Problem
- Nausea/ Vomiting
- Abdominal Pain
- Ulcer
- Poor Appetite
- Liver Problems
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Tuberculosis
- Shortness of Breath
- Emphysema
- COPD
- Cold/Flu
- Cough/Wheezing

ENDOCRINE

- Diabetes Type I or II
- Thyroid – Hyper or Hypo
- Hair Loss
- Excessive Thirst

Review of Systems

Please mark each item below for each sign or symptom you currently have or previously had:

Mark "C" for current Mark "P" for past

NEUROLOGIC

- Stroke
- Seizures
- Head Injury
- Brain Aneurysm
- Numbness
- Severe Headaches
- Pinched Nerves
- Parkinsons
- Stiff Joints
- Carpal Tunnel
- Spinning/Balance
- Multiple Sclerosis
- Migraines

ALLERGIC/IMMUNOLOGIC

- Hives
- Immune Disorder
- HIV/AIDS
- Allergy Shots
- Cortisone Use

HEMATOLOGIC/LYMPHATIC

- Hepatitis
- Blood Clots
- Cancer
- Easy Bruising
- Easy Bleeding
- Fevers/Chills/Sweats

PSYCHIATRIC

- Depression
- Anxiety Disorder
- Unusual Stress
- ADHD
- Mental Disorder
- Alcoholism
- Drug Addiction

WOMEN ONLY

- Difficult Periods
- Hot Flashes
- Irregular Cycles
- Breast Pain
- Lump In Breast
- Difficulty Becoming Pregnant
- Pregnancy Complications
- Pain With Intercourse
- Pelvic Pain
- Cramps
- Birth Control
- Pregnant At This Time
- Date Of Last Period Ended
- Last Gynecologic Exam

MEN ONLY

- Testicular Pain
- Prostate Problems
- Difficult Erection
- Low Sperm Count
- Pain With Intercourse
- Pelvic Pain

Are you currently taking medication? **Y** or **N** List medications below or have front desk make copy of your list:

List conditions you are taking medications for: _____

Do you take Vitamins/Supplements? Y/N If yes, type and how often _____

Anything else you would like us to know regarding your health or reason for seeking care?



Patient Name: _____

To the patient: Please read this entire document prior to signing it as it is important that you understand the information it contains. Please ask questions before you sign if there is anything that is unclear.

Which of our services are you interested in receiving? Check the following that apply:

- | | |
|---|--|
| <input type="checkbox"/> ART/Graston Soft Tissue Work | <input type="checkbox"/> Trigger point dry needling |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Infrared sauna |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Food intolerance testing |
| <input type="checkbox"/> Nutrition and vitamins | <input type="checkbox"/> NutrEval nutritional testing |
| <input type="checkbox"/> Neuro-Emotional Technique | <input type="checkbox"/> I will let the doctors explain what they feel is best and we will determine a plan together |
| <input type="checkbox"/> Functional medicine | |

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- | | |
|---|---|
| <ul style="list-style-type: none">• spinal manipulation therapy• range of motion testing• muscle strength testing• ultra sound• palpation• special imaging/ labs | <ul style="list-style-type: none">• orthopedic testing• postural analysis• hot/cold therapy• vital signs• basic neurological testing• electro-therapy muscle stimulation |
|---|---|

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patient will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history, examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer postponed.

Patients of Back in Line (initial all that apply):

I allow all doctors affiliated and contracted through Back in Line Family Chiropractic and Wellness to have access to my entire health record.

I am comfortable with the doctors referring to the best physician in-office to co-manage/treat me to save me time and money as it pertains to my health and specific conditions I may have

I understand I can request a specific doctor each office visit regardless of my condition

if my primary chiropractor is out-of-town/gone, I am comfortable with seeing another doctor in office

I realize my health concerns and services my fall out of “covered” services for chiropractic benefits.

Initialing here , I understand that care I maybe seeking falls into the CAM category and I maybe personally financially responsible for such care including and not limited to lab testing, health consult, acupuncture, NET, health coaching and counseling, health history review beyond musculo-skeletal pain, medication nutrient depletion. You will be given the option to reject non-covered services

Initial here that you are entering into an agreement that it is the doctors duty to treat your health concerns as their own. They will explain their treatments & options that they feel will get you better as quickly as possible. They work to honor your time, your money, and your health. They will not sacrifice quality of care at your financial expense. They will not sacrifice quality treatment for your health.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment which extends to other doctors and staff members at BIL.

Date: _____

Patient's Name (print)

Signature

Signature of Parent or Guardian (if a minor)



REQUIRED PERSONAL INJURY FORMS

Office Policies

Personal Injury cases are accepted in our office. All personal injury cases, whether car or home accidents, must provide necessary information regarding your personal car insurance, the “at fault” insurance, your commercial health insurance, as well as the accident report, and attorney name and contact information if one has been retained.

The personal car insurance is needed because most individuals have medical benefits (usually called “Medpay” or “PIP”) included in their automobile policies and some do not even realize it. If these benefits are available on your policy, our office requires that you use them in the event that your injuries are as a result of an automobile accident.

The following outlines why we require Medpay or PIP be filed:

1. Medpay and PIP are exactly like health insurance – using either form of coverage does not cause your rates to go up. However, if your rates are increased it is not because of the medpay was filed. It is most likely because: (a) the accident was determined by the insurance company to be your fault, (b) you received a police citation or ticket, and (c) you have been involved in numerous reported auto accidents within a brief period of time and are therefore considered “high risk”.
2. Filing your Medpay or PIP does not relieve the “at Fault” party from having to pay in full for your loss. Filing Medpay or PIP does not relieve the other party from being held responsible for payment. If the “at fault” driver’s liability insurance refuses to make payment on your medical bills for whatever reason, filing your Medpay/PIP will help ensure that you are not left to pay these expenses out of pocket.
3. We do not charge for filing your Medpay or PIP.

As long as Back in Line Family Chiropractic and Wellness is filing my Medpay/PIP and, the insurance company is continuing to cover the charges accrued, collection of payment at time of service will be waived. If overpayment on my account is made, Back in Line Family Chiropractic and Wellness. will refund the difference. I clearly understand and agree that all services rendered to me are charged directly to me, thus, I am personally responsible for payment in full.

Signature below of patient/Guardian indicates that you have read and accept above provisions.

Signature of Patient or Guardian: _____ Date: _____

Printed Name: _____



REQUIRED PERSONAL INJURY FORMS

Contractual Lien

I hereby authorize and direct you, the insurance company, and/or my attorney, to pay directly to:

Name of Doctor

Such sums that may be due and owing this office for services rendered to me, both by reason of accident, of illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, liability benefits, health and accident benefits, workmens' compensation benefits, or any other insurance benefits obligated reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office.

I hereby further give a lien to said office against any and all insurance named herein, and any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this assignment, lien and authorization does not contribute any consideration for the office to await payments and they may demand payment from me upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company or attorney to facilitate collection under this assignment, lien and authorization.

I agree that the above mentioned office be given power of attorney to endorse my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and reimburse this office for all costs of such collection efforts including but not limited to all court costs and attorney fees.

I acknowledge my acceptance by my signature, which is witnessed and notarized to waive use of the above general statutes. Please acknowledge this letter by signing below.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on my current balance.

By signing below, I acknowledge I have read, understand and agree to the above provisions.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

Name of custodial parent or Legal Guardian (please print): _____

Parent/Guardian Signature: _____