BACK in line
FAMILY CHIROPRACTIC AND WELLNESS

Office use only:

BP: _____/_____

Pulse:_____

Height:_____

Weight:_____

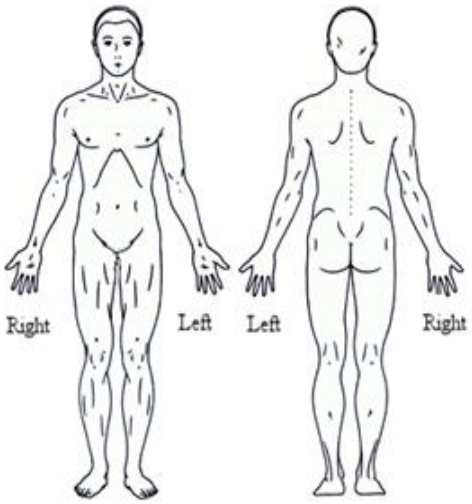
PATIENT NAME:	DATE:	
ADDRESS:	CITY:	STATE/ZIPCODE:
HOME PHONE NUMBER:	CELL PHONE NUMBER:	
EMAIL:	DATE OF BIRTH:	GENDER:
REFERRED BY NAME (FRIEND, FAMILY, OTHER) MAY WE THATNK THEM? Y or N		
OCCUPATION:	EMPLOYER:	

ACCIDENT INFORMATION

AUTO INSURANCE COMPANY NAME:	
POLICY NUMBER:	CLAIM NUMBER:
DATE OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? DRIVER PASSENGER OTHER
WHAT DIRECTION DID THE IMPACT COME FROM? BEHIND FRONT RIGHT LEFT	
APPROXIMATE SPEED YOU WERE TRAVELING?	APPROXIMATE SPEED THE OTHER DRIVER WAS TRAVELING?
WHERE WERE YOU LOOKING AT THE TIME OF IMPACT? STRAIGHT AHEAD DOWN RIGHT LEFT	
WHAT HAPPENED AFTER THE IMPACT? DISORIENTED DISCOMFORT IMMEDIATE PAIN TIGHTNESS LOST CONSCIOSNESS FRIGHTENED STUNNED WENT TO HOSPITAL	

What is your chief 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?_____

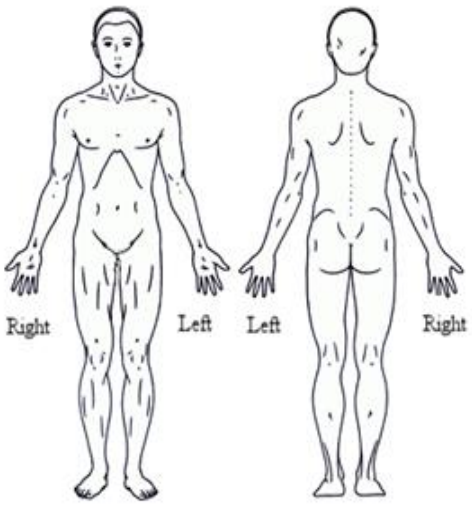
What percentage would you say that the discomfort improves?_____

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**

Second complaint:_____

Mark where your pain is



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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?_____

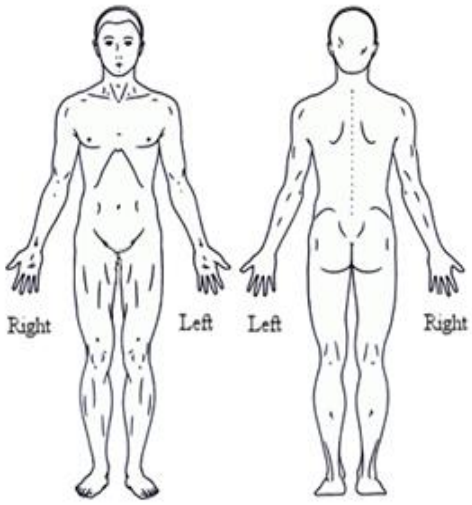
What percentage would you say that the discomfort improves?_____

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 third complaint:_____

Mark where your pain is



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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?_____

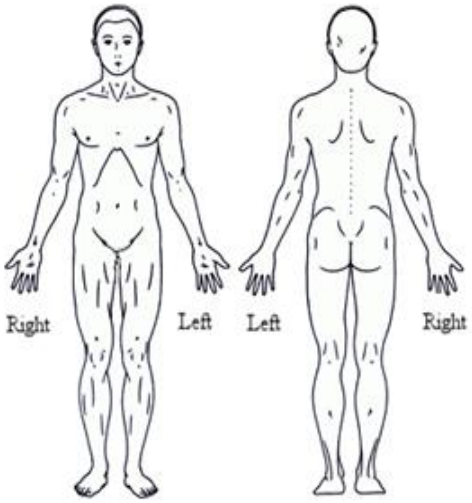
What percentage would you say that the discomfort improves?_____

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



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What is the frequency of the discomfort you are feeling?

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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

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

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

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?

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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:

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

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:

- spinal manipulation therapy
- range of motion testing
- muscle strength testing
- ultra sound
- palpation
- special imaging/ labs
- 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)**

BACK in line
FAMILY CHIROPRACTIC AND WELLNESS

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:_____

BACK in line
FAMILY CHIROPRACTIC AND WELLNESS

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:_____