BACK in line
FAMILY CHIROPRACTIC AND WELLNESS

Office use only:
BP: _____/_____
Pulse:_____
Height:_____
Weight:_____

CASE HISTORY

Name _____Age _____Today's Date _____
Address _____ City _____ State_____ Zip_____
Phone (Home) _____(Cell & Carrier)_____ _____(Work)_____
Date of Birth _____ Sex: Select Marital Status: Select
Email_____

(We promise this is not for spam, and we won't share it your email! We may need to email lab results, billing changes, or newsletters.)

Occupation _____ Employer _____

If under 18 please fill out parent/guardian information:

Parent Name _____ Contact Phone_____
Parent Name _____ Contact Phone_____
Insured's Name _____Insured's Date of Birth _____
Do you have a high deductible? ☐ Yes ☐ No
Would you like guidance on cost saving options for your treatment at our clinic? ☐ Yes ☐ No
Present condition due to an injury at **Work?** ☐ Yes ☐ No __ **OR** injury from **Auto Accident**? ☐ Yes ☐ No
Has the accident been reported? ☐ Yes ☐ No __ To: Employer _____ Auto Insurance _____

Referred by (Friend, Family, Other) _____ **MAY WE THANK THEM?** Y or N

HEALTH REPORT

Reason for seeking care:_____

When did the problem start and cause?: _____

List any other doctors, tests and imaging done for this condition:_____

_____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? ☐ Yes ☐ No If yes, explain: _____

Have you received chiropractic treatment previously? ☐ Yes ☐ No
If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, explain: _____

List any significant health history and approximate dates(surgeries, trauma or health conditions not noted)

_____

_____

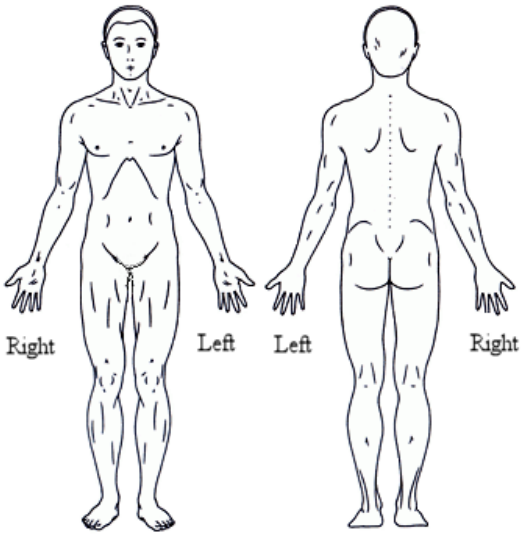
Do you have any children? ☐ Yes ☐ No If yes, what age/ages?_____

Family History: Good health? Health conditions, age:

Father/Mother: _____

Siblings:_____

Do you smoke? Sel ____ packs/day ___years Alcohol? Drinks/week _____ Caffeine cups per day ____
Exercise: ☐ none ☐ 1-2x per week ☐ 3-4x per week ☐ 5-7x per week. What type?_____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10 Select

Using the symbols below, mark on the pictures where you feel pain or symptoms

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

What activities aggravate your condition/pain?
Sit Stand Stretch Walk Laying Lifting Working out Driving
What activities lessen your condition/pain?
Sit Stand Stretch Walk Laying Lifting Working out Driving
Is this condition worse during certain times of the day? Select
Is this condition interfering with: Work?_____
Sleep?_____Routine?_____Other?_____
Is this condition getting better, worse or staying the same?_____

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

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

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

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

INTEGUMENTARY
__ Skin Ulcers
__ Skin Disease
__ Eczema
__ Psoriasis
__ Rashes
__ Dryness
__ Sensitive Skin
__ Boils

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

ENDOCRINE
__ Diabetes Type I or II
__Thyroid – Hyper or Hypo
__ Hair Loss
__ Excessive Thirst

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? Select 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
___ Depends on what my insurance covers
___ 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)**

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It is the intention of all personnel in this office to provide for your chiropractic needs as thoroughly and efficiently as possible. Therefore, we wish to acquaint you with our policies.

The initial appointment is spent conducting a thorough examination. It includes a clinical examination, history of symptoms, and possibly X-rays and labs, as indicated. “To see is to know, not to see is to guess”. The more comprehensive the examination, the more intelligently we can diagnose and treat. From our clinical findings, we will diagnose your case and discuss present and recommend proper treatment.

INSURANCE

_____ We participate, and submit to, a variety of health care insurance programs which aid in the payment of your medical costs. Should there be problems with an insurance claim, first direct your question to your insurance carrier. Our Insurance Office will be pleased to help you if they can be of any assistance in resolving a problem. It is YOUR responsibility to know if your insurance covers chiropractic care, or if you need to have pre-approved visits.

MEDICARE

_____ Coverage of chiropractic services is specifically limited to manual manipulation of the spine to correct a subluxation. Medicare DOES NOT PAY FOR EXAMS, X-RAYS, THERAPIES, SUPPLEMENTS, OR ANY OTHER SERVICES RELATED TO CHIROPRACTIC CARE.

MEDICAID

_____Coverage of chiropractic services is specifically limited to manual manipulation of the spine and X-rays. If Medicaid is secondary to Medicare, Medicaid may not pay for X-rays. Medicaid DOES NOT PAY FOR EXAMS, THERAPIES, SUPPLEMENTS, OR ANY OTHER SERVICES RELATED TO CHIROPRACTIC CARE.

NO INSURANCE (TOS)

_____ If you have no insurance covering chiropractic care we request services be paid in full for the first visit at the first visit, and full payment at every visit thereafter.

PAYMENT

__X_ If your insurance policy has a deductible or co-payment amount, it must be paid at the time of service. Your health insurance policy is an arrangement between you and your health insurance carrier, and you are ultimately responsible for all fees relating to your care.

USUAL AND CUSTOMARY RATES

__X__ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company’s arbitrary determination of usual and customary rates.

I HAVE REVIEWED, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES.

Patient Signature_____ Date _____

Parent/Legal Guardian Signature _____ Date _____