

► Please print and fill out this form before coming to your first appointment.



New Patient Intake Form

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Cell Phone (____) _____ - _____ Email _____

Date of Birth ____/____/____ Sex: Male Female

Marital Status: Single Married Other

Employer Data

Employer _____

Your Occupation _____

Spouse Data

First Name _____ Middle Initial ____ Last Name _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Spouse Date of Birth ____/____/____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Insurance info

Insurance Company _____ ID # _____

Name of Insured _____

Relationship to patient _____

Address of Insured _____

City, State, Zip _____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

- Arthritis Cancer Diabetes Heart Disease
- Hypertension Psychiatric Illness Skin Disorder Stroke
- Other _____ Fibromyalgia Asthma Osteoporosis

Surgeries: (Circle all that apply to you)

- Appendectomy Cardiovascular procedure Cervical spine Hysterectomy
- Joint Replacement Prostate Lumbar spine Gall Bladder
- Brain Shoulder Thoracic spine Knee
- Carpal Tunnel Gastro-intestinal Uro-genital Hernia
- Breast Augmentation Other _____

Allergies: (Circle all that apply to you)

- Mold Seasonal Milk or Lactose Animal
- Chemical _____ Sulfites Wheat/Glutens Other _____

Social History: (Circle all that apply to you)

- Caffeine use: occasional often never
- Drink Alcohol: occasional often never
- Exercise: occasional often never
- Drink Water: <64 oz/day >64 oz/day never
- Cigarettes: <1 pack/day >1 pack/day never
- Sleep: <8 hours/night >=8 hours/night Insomnia
- Other _____

Family History: (Circle all that apply)

- Arthritis: Parent Sibling
- Cancer: Parent Sibling
- Diabetes: Parent Sibling
- Heart Disease Parent Sibling
- Hypertension Parent Sibling
- Stroke Parent Sibling
- Thyroid Parent Sibling
- Other _____

Occupational Activities: (Circle one that best describes your job description)

- Administration Business Owner Clerical/Secretary Computer User
- Heavy Equipment operator Daycare/Childcare Construction Health Care
- Food Service Industry Medium Manual Labor Manufacturing Home Services
- Heavy Manual Labor Light Manual Labor Executive/Legal Housekeeper
- Other _____

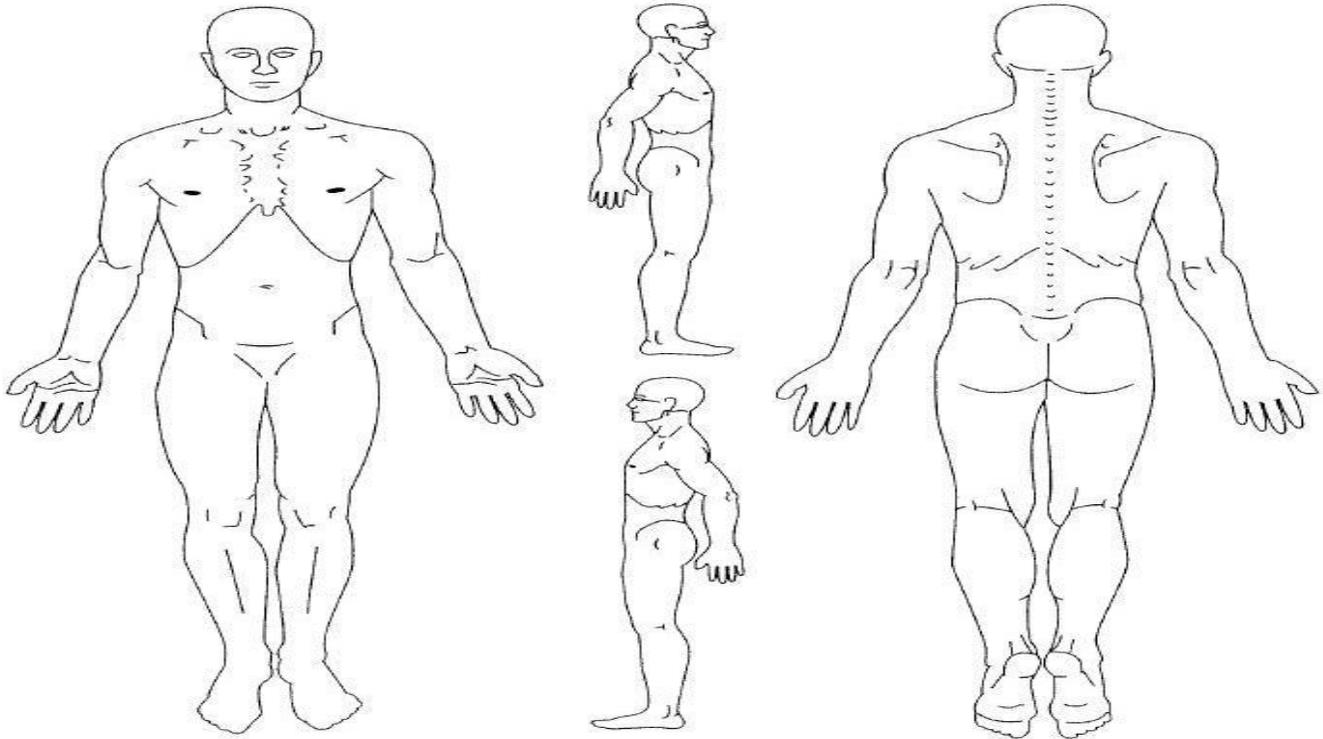
Patient Name _____ Date _____

Please list all current medications and supplements being taken:

How are your symptoms changing? Getting better Not changing Getting worse

Are You Pregnant? Yes No If yes, how far along are you? _____

“X” where you are having any pain, numbness, tingling, or burning.



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No If Yes, please list: _____

When did your symptoms begin? _____

Are your symptoms a result of: Work related Accident Other _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- Sharp
- Ache
- Numb
- Shooting
- Burning
- Tingling
- Throbbing
- Other _____

Patient Name _____ Date _____

PAYMENT POLICY

Thank you for choosing Back to Balance Chiropractic as your Chiropractic provider. We are committed to providing you with quality and affordable health care. Due to some of the questions our patients have regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we do participate with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit. We are only able to provide a summary of your chiropractic benefits.
2. **CO-PAYMENT AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help is in upholding the law by paying your co-payment at each visit.
3. **PROOF OF INSURANCE.** All patients must complete out patient information form before seeing the provider. We must obtain a copy of your most current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
4. **CLAIM SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. **CONVERAGE CHANGES.** If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. **CASH DISCOUNT.** We offer discounts for cash at time of service.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understood the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- A. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following manipulation.
- B. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- C. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote. This is especially true when the care is given by a licensed chiropractor.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall wellbeing. The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed the following with my healthcare provider:

- A. The condition that the treatment is to address
- B. The nature of the treatment
- C. The risks and benefits of that treatment
- D. Any alternatives to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Nate Roberts, DC or Leslie Bateman, LMT.

Patient or Guardian Signature Date

Print Name