Patient Information

Name: First_____ Last _____M.I. ___ Date:_____

Preferred Name:_____ Date of Birth: _____ SSN: _____

Address:_____ City:_____

State:_____ Zip:_____ Email: _____

Phone:_____ Cell/Home/Work (please circle one)

How did you hear about us? Door hanger, Fargo Forum, Driving by, Internet, Referred, Magazine, Other.
If other, please explain_____

If referred, whom may we thank for referring you to us:_____

Are You: ____Minor ____Single ____Married ____Divorced ____Widowed

Your Employer:_____ Occupation:_____

Emergency Contact:_____ Phone#:_____

Relation to Emergency Contact:_____

This office utilizes an automated appointment reminder system for its patients. To receive a reminder phone call/email for your visits, please list the phone number and email that you prefer to be contacted at.

Preferred way of Contact (circle one or both) Phone Email

The following demographic information is required by the Secretary of Health and Human Services when utilizing electronic health records. We thank you for your cooperation.

Preferred language:_____Race:_____Ethnicity:_____

Insurance Information ____Check here if you currently have no insurance

If we have taken a copy of your insurance card, it is not necessary to complete the remainder of this form.

Insurance Company:_____Phone#:_____

Address:_____City:_____State:_____Zip:_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Number:_____Group Number:_____

BALANCE RESTORED Chiropractic

Health Survey

Current Complaints

Patient Name: _____ **Date:** _____

Describe your symptoms:_____

_____

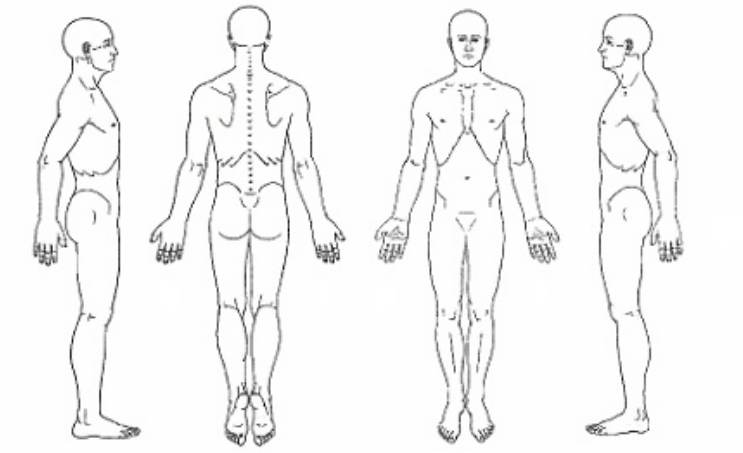
_____

When did your symptoms start? _____

How did your symptoms begin? _____

Have you had this condition/symptoms before? If yes, when? _____

Please indicate where pain and symptoms are located



Describe the Symptoms? (circle any)

Sharp? Shooting?
Dull/Ache? Burning?
Numb? Tingling?

Are the symptoms changing?

Staying the same
Getting better
Getting worse

How often are you experiencing these symptoms? (circle one)

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

What is the average pain intensity? (0 is no pain, 10 worst pain)

Last 24 hours:	0	1	2	3	4	5	6	7	8	9	10
Past 4 weeks:	0	1	2	3	4	5	6	7	8	9	10

Have you seen anyone else for this complaint?

No one/ Medical Doctor/ Physical Therapist/ Other Chiropractor

If so, what treatment and when? _____

What tests have you had done and when?

X-ray, date: _____ MRI, date: _____

CT, date: _____ Other, date:_____

Have you had similar issues in the past? Yes No

If so, did you see anyone and when? Date: _____

Medical Doctor/ Chiropractor/ Physical Therapist/Other Chiropractor

Does this condition interfere with:

Work Sleep
Daily Activities Other

Explain: _____

How would you describe your overall health?

Excellent Very Good Good
Fair Poor

Patient Signature_____ **Date:** _____

BALANCE RESTORED Chiropractic

Health Survey

Patient Name_____ **Height** _____ **Weight**_____

For each condition below please check all that applies:

Past/Present

- ☐ ☐ Headache
- ☐ ☐ Neck Pain
- ☐ ☐ Upper Back Pain
- ☐ ☐ Mid Back Pain
- ☐ ☐ Lower Back Pain
- ☐ ☐ Shoulder Pain
- ☐ ☐ Elbow/Upper Arm Pain
- ☐ ☐ Wrist Pain
- ☐ ☐ Hand Pain
- ☐ ☐ Hip/Upper Leg Pain
- ☐ ☐ Knee/Lower Leg Pain
- ☐ ☐ Ankle/Foot Pain
- ☐ ☐ Jaw Pain
- ☐ ☐ Joint Swelling/Stiffness
- ☐ ☐ Arthritis
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ General Fatigue
- ☐ ☐ Muscle Uncoordination
- ☐ ☐ Visual Disturbance

Past/Present

- ☐ ☐ Dizziness
- ☐ ☐ High Blood pressure
- ☐ ☐ Heart Attack
- ☐ ☐ Chest Pain
- ☐ ☐ Stroke
- ☐ ☐ Angina
- ☐ ☐ Kidney Stones
- ☐ ☐ Kidney Disorder
- ☐ ☐ Bladder Infection
- ☐ ☐ Painful Urination
- ☐ ☐ Bladder Control Loss
- ☐ ☐ Abdominal pain
- ☐ ☐ Ulcer
- ☐ ☐ Hepatitis
- ☐ ☐ Liver/Bladder Disorder
- ☐ ☐ Cancer
- ☐ ☐ Tumor
- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Diabetes

Past/Present

- ☐ ☐ Excessive Thirst
- ☐ ☐ Frequent Urination
- ☐ ☐ Tobacco Use
- ☐ ☐ Drug/Alcohol Dependency
- ☐ ☐ Allergies
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Systemic Lupus
- ☐ ☐ Epilepsy
- ☐ ☐ Dermatitis/Eczema
- ☐ ☐ HIV/AIDS

Other Health Problems

- ☐ ☐
- ☐ ☐

Female Only

- ☐ ☐ Birth Control
- ☐ ☐ Hormonal Replacement
- ☐ ☐ Pregnancy

Please describe all check briefly here_____

_____

_____

Indicate if an immediate family member has had any of the following:

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐_____

List all prescriptions, over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

_____

List all surgical procedures you have had and times you have been hospitalized (with the dates):

_____

_____

Patient Signature: _____ **Date:** _____

Financial Policy

Our passion is to provide the highest quality of healthcare possible to our patients. In order to achieve this, we need your commitment as well.

- We urge our patients to follow the doctors' recommendations for care to see the intended results. Please keep your appointments as scheduled or call our office within 24 hours to make any changes.
- I authorize Balance Restored Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement charges incurred by me.
- In order to file your claims in a timely manner, we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for care; however, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers and what it doesn't. Should your insurance carrier determine that your any or all of our services are ineligible for payment, you will be billed for those services.
- If you have any questions about our financial policies, please ask our staff. If you need to make special arrangements, please ask. We will do everything possible to meet your financial needs.
- *Advanced Beneficiary Notice of NON-Coverage (ABN). Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. If you have other questions, please ask our staff. Signing below means that you have received and understand this notice.*

Signature: _____ Date: _____

Relationship to Patient (if applicable): _____

HIPAA Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certi cates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed.

Print Patient Name:_____ Date: _____
Signature:_____
Relationship to Patient (if applicable): _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric stimulation, therapeutic ultrasound and exercise, etc. may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligament sprain, dislocations of joints, or injury to intervertebral discs, nerves or the spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare". The risk of cerebrovascular injury or stroke, has been estimated at on in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

PATIENT: _____ _____ _____
Printed Name Signature Date

WITNESS: _____ _____ _____
Printed Name Signature Date