purebalance
chiropractic yoga pilates

DATE_____ ***PATIENT INFORMATION***

Patients Full Name_____ Birthdate_____
First Middle Last

Physical Address_____ City_____ State_____ Zip_____

Mailing Address (if different)_____ City_____ State_____ Zip_____

E-Mail Address_____ Circle YES / NO to sign up for our newsletter!

Age_____ Sex_____ Height_____ Weight_____ No. of Children_____ Marital Status: S M D W

Occupation_____ Employer_____ Social Security #_____

Spouses Name_____ Occupation_____ Employer_____

Spouses Social Security #_____

PHONE NUMBERS

Home Phone_____

Cell Phone_____

Work Pnone_____

Nearest relative NOT living with you
Name_____
Home # _____
Cell #_____

Nearest friend NOT living with you
Name_____
Home #_____
Cell #_____

ACCIDENT INFORMATION

Is this due to an accident? YES NO

Type of Accident
(circle one)

Auto Work Home Other

Who have you reported this accident to?

Auto Ins____ Employer_____ Other_____

Attorney's Name_____

INSURANCE INFORMATION

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co._____

ID #_____

Is patient covered by additional Insurance? YES NO

Subscribers Name_____

Birth Date_____ SSN_____

Relationship to patient_____

Insurance Co._____

ID #_____

If patient is a minor, who is financially responsible for this bill?

First _____ M.I._____ Last_____

Address_____City_____St_____

Relationship_____ Home #_____

Cell #_____ SSN#_____

How did you hear about us?

Internet_____ Insurance_____ Walked by____ Referral _____ Other_____

Patient Name_____ **Date**_____

HEALTH HISTORY

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Please check all the appropriate boxes for any of the following symptoms which you now have or have had previously. It is very important that we have all the facts about your health before we treat you. ***THIS FORM IS CONFIDENTIAL.***

□ AIDS/HIV	□ Cataracts	□ Hepatitis	□ Osteoporosis	□ Suicide Attempt
□ Alcoholism	□ Chemical Dependency	□ Hernia	□ Pacemaker	□ Thyroid Problems
□ Allergy Shots	□ Chicken Pox	□ Herniated Disc	□ Parkinson's Disease	□ Tonsillitis
□ Anemia	□ Depression	□ Herpes	□ Pinched Nerve	□ Tuberculosis
□ Anorexia	□ Diabetes	□ High Cholesterol	□ Pneumonia	□ Tumors, Growths
□ Appendicitis	□ Emphysema	□ Kidney Disease	□ Polio	□ Typhoid Fever
□ Arthritis	□ Epilepsy	□ Liver Disease	□ Prostate Problems	□ Ulcers
□ Asthma	□ Fractures	□ Measles	□ Prosthesis	□ Vaginal Infections
□ Bleeding Disorders	□ Glaucoma	□ Migraine Headaches	□ Psychiatric care	□ Venereal Disease
□ Breast Lump	□ Goiter	□ Miscarriage	□ Rheumatoid Arthritis	□ Whooping Cough
□ Bronchitis	□ Gonorrhea	□ Mononucleosis	□ Rheumatic Fever	□ Other_____
□ Bulimia	□ Gout	□ Multiple Sclerosis	□ Scarlet Fever	_____
□ Cancer	□ Heart Disease	□ Mumps	□ Stroke	_____

Please list any medications or supplements that you are currently taking_____

Are you allergic to any medication? (please list)_____

Have you ever been hospitalized? (describe)_____

Please describe any surgeries that you have had_____

Have you ever seen a chiropractor before? _____ if so, who & when?_____Did it help? YES NO

Do you exercise? (circle one) NONE MODERATE DAILY HEAVY

Describe your NORMAL work activity: (circle one) SITTING STANDING LIGHT LABOR HEAVY LABOR

HABITS

Smoking- YES NO Packs per day___ How long____
Alcohol- YES NO Drinks per day___ How long___
Caffeine- YES NO Drinks per day___ How long___

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Date of last exam_____

Are you pregnant? YES NO Due Date_____ Nursing? YES NO Taking Birth Control? YES NO

Please circle your stress level:

Low 1 2 3 4 5 High Cause: WORK FAMILY FINANCIAL PAIN OTHER_____

How often do you exercise and what form? _____

How would you describe your diet and eating habits? _____

Patient Name_____ **Date**_____

TELL US WHY YOU ARE HERE TODAY

Reason for visit_____ When did symptoms appear?_____

Which activities are difficult to perform? □ Sitting □ Standing □ Walking □ Bending □ Lying down □ Other

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Shooting □ Tingling □ Stiffness □ Burning
□ Aching □ Swelling □ Cramps □ Other_____

How often do you have this pain?_____ Is it consistent or does it come & go?_____

As a result of your symptoms, are you restricted in your ability to perform work and/or daily activities? YES NO
If yes, please describe_____

Do you have any other symptoms that you feel are associated with your current condition?_____

What treatment have you received for this condition? □ Chiropractic □ Physical Therapy □ Surgery □ Medication

Have you ***ever*** had x-rays taken? YES NO

List any accidents and/or falls and their dates:

Car_____

Sports_____

Other_____

List any other broken bones or dislocations:_____
Have you ever had any spinal taps or spinal injections? (circle one) YES NO
Have you ever been knocked unconscious? (circle one) YES NO
Have you ever had a lapse of memory? (circle one) YES NO
Do you suffer from any other condition other than that for which you are now consulting us?_____

DOCTOR'S NOTES:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Pure Balance will submit claims to my insurance company as a courtesy. However, I am fully responsible for all charges due to services rendered. All charges must be paid at the time of services. This includes co-pays and deductibles. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor any medical diagnosis.

*Patient's signature*__*Date*_____

CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, cold application, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Patient signature Date

Please read the following carefully and initial each statement.

_____ I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the chiropractic physician because it may affect care.

_____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Pure Balance reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

Notice: Patient Privacy

How Medical Information About You May Be Used and Disclosed and How You Can Access This Information.

We are committed to protecting the privacy of your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996, we are required by law, to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide, and related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information and/or records for other purposes without your consent or authorization.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our notice from time to time. The effective date is the date signed and indicates the date of the most current notice in effect.

You have a right to receive a copy of our most current notice in effect. If you have not yet reserved a copy of our current notice, please ask the front desk and we will provide you with our most current copy.

If you have any questions, concerns or comments about the notice or your medical information, please contact our office at (281)251-4400.

_____ _____

Signature Date

_____

Printed patient name