

Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

Patient Information

(Our goal is our patient's care and satisfaction; please complete this form in its entirety)

*****There are front and back sections to fill out.*****

Name _____

Date _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Status: Single Married Other

Work Phone (_____) _____

Cell phone (_____) _____

Date of Birth _____ Age _____ Male Female

Email _____ (we send receipts electronically please provide)

Name of Emergency Contact _____

Emergency Contact Telephone# _____

Employer _____

Position _____

Have you ever received Chiropractic Care? Yes No

Referred to this office by: Friend/Family Member - Name? _____

Internet _____ Other _____

Are you covered by more than one insurance company? ____ Yes ____ No



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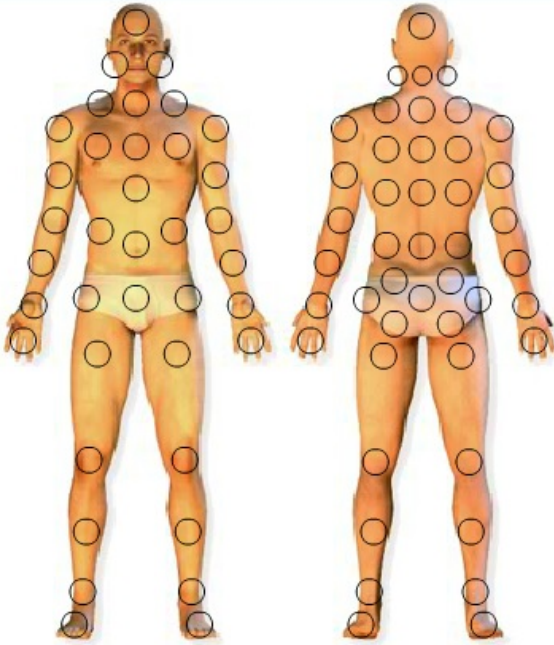
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NAME _____

OCCUPATION _____ EMPLOYER _____

Where is Chief Complaint? ?

****Using the symbols below, Fill in the circles on the pictures where you feel pain with the below symbols****



<u>Description</u>	<u>Symbols</u>
Numbness	1
Dull Ache	2
Burning	3
Sharp/Stabbing	4
Pins, Needles	5
Other _____	6

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Primary complaint _____

Pain or Problem started on _____

Reason of Injury/Complaint: _____

Healthcare practitioner seen for this condition _____

Please Describe Your Present Conditions (List Each Body Part Separately 1-4)

1. Body Area _____ (example: low back, neck, headache)

Does it radiate and if so where to: _____

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Constant Frequent Intermittent On and off Random

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

Chiropractic Care (adjustments) Cold/Ice pack Exercise Heat packs Massage Nothing

Over the counter medication Physical Therapy Prescription medication Rest Stretching Work Walking

Other _____

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PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

- Almost any movement Bathing Bending Caring for family Carrying changing positions Climbing Stairs
 Computer Use Concentrating Cooking Coughing Sneezing Daily child care Daily pet care Driving
 Eating Falling or Staying asleep Getting in or out of the car Getting out of Bed Getting up from a lying down position
 Getting up from sitting Grocery Shopping Household Chores Lifting Looking over shoulder Lying down
 Pulling Pushing Reaching Reading Repetitive Motions Resting Running Sitting Squatting
 Standing Stress Stretching Talking on the Telephone Turning Twisting Walking Working Yard Work
 Other _____

Previous episodes of complaint: _____

Previous Care for this complaint: _____

Recent Diagnostic tests: _____

Activity of daily living most affected?

- Employment Homemaking Lifting Personal Care (washing, dressing, etc.) Sitting Sleeping Social Life
 Standing Traveling and/or Driving Walking
 Other _____

What do you have difficulty performing due to this specific complaint? (Choose all the apply)?

- Bending over Caring for Family Climbing Stairs Concentrating Dressing self Driving Car Exercising
 Getting in or out of the car Getting to Sleep Grocery Shopping Performing Household Chores Lifting Objects
 Looking over shoulder Making Love Lying down Reaching over head Rising our of chair or bed
 Showering or bathing Sitting Standing Staying asleep Using a Computer Walking Participation in Yard Work
 Other _____

Have you had surgery? Y N

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Drugs, prescription, OTC, recreational?

1. _____ Treating? _____
2. _____ Treating? _____
3. _____ Treating? _____
4. _____ Treating? _____

Vitamins, Minerals, Health drinks?

1. _____ 2. _____
3. _____ 4. _____

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Current Health Habits:

*Patient Comments

If answer is Yes (please give more details, ex. How much, How often etc...)

Did/do you smoke? Y N _____

Did/do you drink alcohol? Y N _____

Exercise regularly? Y N **How often?** _____

Did/do you have occupational stress? Y N _____

Drive? Daily time spent driving Y N _____

Physical stress? Y N _____

Emotional/Mental stress? Y N _____

Hobbies/Sports injuries? Y N _____

Do you sleep well, hours of sleep? Y N _____

Sleeping posture? Side _____ Stomach _____ Back _____

Do you have urinary, kidney or bladder problems? Y N _____

Have you lost any weight in the past year without trying to? Y N _____

Does your pain wake you at night? Y N _____

Have you had a change in bowel or bladder habits? Y N _____

Have you had / do you have chest pain? Y N _____

Have you had a concussion? Y N _____

Have you had / do you have dislocated joints? Y N _____

Have you had / do you have headaches? Y N _____

What are the physical demands of your Job (circle one): Light Moderate Heavy

How would you consider your average diet (circle one): Balanced Fair Poor Excessive Restricted

Do you use any of the following (circle all that apply): Caffeine Tobacco Recreational drugs Soda

Have you been in accidents/trauma? Y N Job Auto Other 1. _____

Dates of accidents/trauma: _____

List physical injuries such as falls, head injury, sprains, strains, broken bones:

Do You Have Children None Boys ages _____ Girls ages _____ Are you Pregnant? Yes No

Are both your parents still alive? Y N (please explain cause(s) death below) example (heart attack):

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Medical/Family History S = Self M = Mother F=Father

(Please indicate which **past** conditions have been experienced prior to your present complaint by marking appropriate boxes.)

S	M	F		S	M	F		S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	abdominal aneurism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anorexia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	allergies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	breast lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	epilepsy / seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	herniated disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	migraine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pinched nerve
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	psychiatric care
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	suicide attempt
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tumor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cancer (please provide the type)	_____							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other illness/injury (explain)	_____							

Patient Print Name: _____

Patient Signature : _____ Date _____

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Consent for Treatment & One-Time Authorization

The following information is to be completed by the patient, or the patient's legally authorized representative:

I consent to chiropractic and soft tissue treatment recommended by Dr. Kenneth D'Souza D.C. for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Balance 4 Life Chiropractic will share patient health information according to federal and state law for treatments and payments.

I understand that as the patient I am responsible for all charges incurred, regardless of my health insurance status. I understand that it is my responsibility to obtain and confirm my health insurance benefits with my health insurance company. I agree to pay for services as I incur the charges. I authorize my health insurance company(s) to pay Balance 4 Life Chiropractic for all approved services rendered to me.

Print Patient Name: _____

Signature of Patient: _____

Date: _____

Signature of Legally Authorized Representative: _____

Relationship to Patient: _____

Date: _____

For Medicare Beneficiaries, only:

I request that payment of authorized Medicare and Medigap benefits be made on my behalf for any services furnished to me by or in Balance 4 Life Chiropractic, including provider services. I authorize any holder of medical information about me to release to the Center of Medicare & Medicaid Services (CMS), its agents, and my current Medigap Insurer, any information needed to determine these benefits payable for related services.

Signature: _____

Date: _____

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Office Policies and Procedures

Cancellations/Reschedules: Time has been specifically reserved for your treatment. Please call at least 2 hours ahead to cancel or reschedule an appointment. For Tuesday appointments, please call on the previous Friday as our office is currently closed on Monday. If you fail to cancel your appointment at least 2 hours ahead or fail to show up for your scheduled appointment, the office reserves the right to charge a "No Show Fee". The fee is \$25 for established patients and \$75 for a new patient visit.

Late Arrivals: If you are 15+ minutes late for your appointment, you will need to reschedule and a \$25 late-cancellation fee will be charged. Charges can be eliminated with an advance call with a justifiable reason.

No Shows: Please note that all NO SHOWS will automatically be charged a fee of \$25.00 and \$75 for new patient visits.

NOTE: Insurance/Managed Care does not pay for missed appointments or late cancellations. **Patients are responsible for the fees incurred.**

Billing/Collections: Payment is expected at check-in with the receptionist. For a **Cash** patient, the total amount is required. For **Insurance** patients, the total amount of the visit is due if your deductible has **not** yet been met. If your deductible has been satisfied for the year, no payment is due. For **Medicare** patients, full payment will be due if the annual deductible has not been met. If Medicare patients have a secondary insurance, there is typically no additional payment due once the annual deductible has been met. However, this can vary depending on the secondary insurance company. Medicare patients will be responsible for any amount not reimbursed by Medicare and/or the secondary insurance. Please ask the receptionist at check-in if you have any questions regarding the amount due.

For insurance patients, if the insurance company does not reimburse as expected, a statement of your account will be generated and forwarded to your home address. Payment on this statement is due upon receipt. If payment is not received within 30 days, we reserve the right to turn your account over to collections. The costs associated with the collections will be added to your account.

We value our patient/doctor relationships and will do everything that we can to accommodate you. Your communication and compliancy are very much appreciated.

I, _____, have read and understand the above policy.

Signature: _____ Date: _____