PATIENT INFORMATION

Patient LEGAL Name

_____
First Middle Last

Preferred Name _____ Whom may we thank for referring you? _____

DOB: _____ SSN: _____ Marital Status: S M Other Sex: Male / Female

Address

_____
Street Address

_____
City State Zip Code

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____

Contact Info: Cell ( ) _____ Home ( ) _____

Work ( ) _____ Email _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Method of Appointment Notification:

Text_____ Cell Phone Provider (Circle One): AT&T/Cricket/Nextel/Sprint/T-Mobile/Verizon/Virgin

-or-

Email_____ If different from above, please provide: _____

ACCIDENT INFORMATION, IF APPLICABLE (Personal Injury/Worker's Compensation)

Is this condition due to an accident? ☐ No (If no, skip this section) ☐ Yes (If yes, date of accident _____)

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other_____

Who have you reported this to? ☐ Auto Ins. ☐ Employer ☐ Work Comp. ☐ Other_____

Have you retained an attorney? ☐ No ☐ Yes, Name: _____Ph. ( ) _____

INSURANCE INFORMATION

Please check all that apply: ___Insurance ___Secondary Ins ___Medicare ___Medicare Replacement

Subscriber (Name of person responsible for this account): _____

Subscriber's Employer: _____ Subscriber's DOB: _____ Relationship to Pt:

_____

Primary Insurance Carrier: _____ Ins. Phone: _____

Subscriber ID#: _____ Group #: _____

Do you have any additional medical coverage **(even if you don't think there is a chiropractic benefit)?** YES NO

Secondary Insurance Carrier: _____ Ins. Phone: _____

Subscriber ID#: _____ Group #: _____

**********_For Office Use Only_**********

Staff: _____ Date: _____Dr: ☐ Tyler ☐ Ryan ☐ Heike ☐ Sean

HEALTH HISTORY

Please list any medical conditions you are currently receiving treatment for: _____

Please list any medical conditions you have had treated in the past (including injuries/surgeries): _____

_____

Medications: _____ Allergies: _____

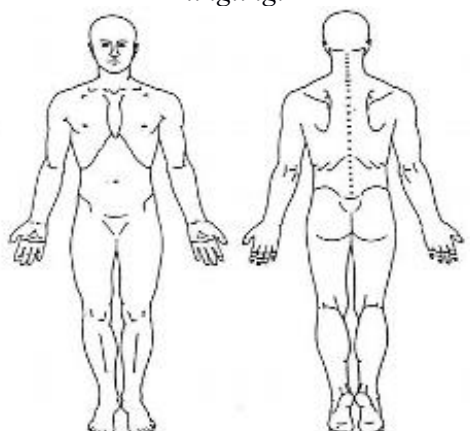
Are you pregnant? ☐ No ☐ Yes, Due Date:_____

PATIENT CONDITION

Please describe your condition when it is at its worst: _____

_____

*Mark an **X** on the picture below where you continue to experience pain, numbness, or tingling.*



Type of pain:

☐ Sharp ☐ Dull ☐ Throbbing
☐ Aching ☐ Shooting ☐ Numbness
☐ Burning ☐ Tingling ☐ Stiffness
☐ Cramps ☐ Swelling ☐ Other

How long have you had these symptoms?

☐ Years ☐ Months ☐ Weeks

Is this condition getting progressively worse?

☐ Yes ☐ No
☐ Comes & Goes ☐ Unknown

Is there any radiation or numbness/pain to your arms or legs? If yes, please describe: _____

_____

Does this problem affect any other areas of your body? If yes, please describe: _____

_____

What aggravates the problem? _____

*What relieves the problem?*_____

If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?

☐ Delighted ☐ Pleased ☐ Mostly Satisfied ☐ Mixed ☐ Mostly Dissatisfied ☐ Unhappy ☐ Terrible

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the aforementioned company(ies) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I have been presented with Back In Motion's Notice of Privacy Practices and understand that I am entitled to a copy upon request. This form has been completed correctly to the best of my knowledge and I understand it is my responsibility to inform the office of any changes to the information I have provided.

Patient Signature _____ Date _____

Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Patient Signature Patient Name (Please Print)

_____

Witness Signature

_____

Date