

PATIENT INFORMATION

Patient LEGAL Name (Last, Middle, First): _____

Preferred Name: _____ Whom May We Thank for Referring You? _____

DOB: _____ SSN: _____ Marital Status: S M Other Sex: M F

Address: _____

Patient Employer/School: _____ Occupation: _____

Contact Info: Cell () _____ Home () _____

Work () _____ Email _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Method of Appointment Notification:

-or- Text Email Cell Phone Provider (Circle One): AT&T/Cricket/Google/Sprint/T-Mobile/Verizon/Virgin
If different from above, please provide: _____

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

Is this condition due to an accident? No Yes (If yes, notify Front Desk and request a Personal Injury Form)

INSURANCE INFORMATION

Please check all that apply: Insurance Secondary Ins Medicare Other _____

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 #: _____

Secondary Insurance Carrier: _____ Ins. Phone: _____

Subscriber ID#: _____ Group #: _____

ASSIGNMENT & RELEASE Please initial acknowledgements below:

_____ I certify that I, and/or my dependent(s), have insurance coverage with the aforementioned company(ies) and assign directly to Doctor Tyler Forbes/Ryan McClinton/Heike Klima/Sean Golden 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. Back In Motion has my permission to contact me via phone/email/mail in relation to the status of my and/or my dependent(s) account and any outstanding balance.

Optional: I authorize Back In Motion to share my billing/health information with _____ (name), my _____ (relationship).

_____ I have been advised of Back In Motion's Cancellation Policy, and acknowledge my responsibility to notify the office should I need to change my appointment date/time at least 24 hours prior to my scheduled appointment in order to avoid a \$50 fee.

_____ This form has been completed correctly to the best of my knowledge and I understand that I will be responsible for charges incurred if the information provided is not correct.

Patient Signature _____ Date _____

****Office Staff Only**** NP EP Entered By: _____ 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

Cramping Swelling Other

How long have you had these symptoms?

Years Months Weeks

Is this condition getting progressively worse?

Yes No

Comes & Goes Unknown

Does it interfere with your:

Work Sleep

Daily Routine Recreation

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain **presently** prevents you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst. **Please circle the number which best describes how your typical level of pain affects these six categories of activities.**

- FAMILY/ AT-HOME RESPONSIBILITIES SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL:**

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					
- RECREATION INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES:**

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					
- SOCIAL ACTIVITIES INCLUDING PARTIES, THEATER, CONCERTS, DINING-OUT AND ATTENDING OTHER SOCIAL FUNCTIONS:**

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					
- EMPLOYMENT INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS:**

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					
- SELF-CARE SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED:**

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					
- LIFE-SUPPORT ACTIVITIES SUCH AS EATING AND SLEEPING:**

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION					TOTALLY UNABLE TO FUNCTION					

SCORE _____ [60]

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