BODY BALANCE
chiropractic wellness rehabilitation

1600 Converse Ave.• Cheyenne, WY 82001
Phone: (307) 632-5901
Fax: (307) 632-4280

New Patient Registration

Please fill out all information with as much detail as possible. If you are unsure about any part of these forms, feel free to ask us any questions.

Fields with an asterisk(*) are required.

*First Name _____ Middle_____ *Last_____

Gender ☐Male ☐Female

*Main Phone ( )_____-_____ Work Phone ( )_____-_____

*Address_____

*City_____*State_____ *ZIP_____

*Birthdate_____ Marital Status: S M W D

E-mail Address:_____

Employer:_____

Job Title_____

How did you hear about our office? Internet Referred Friend:_____

Other:_____

In case of emergency, whom should we contact?_____

Phone_____ Relationship _____

RESPONSIBLE PARTY INFORMATION

Person responsible for this account: ❑ Self/Cash ❑ Insurance ❑ Other: _____

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Policy ID Number:	Policy ID Number:
Group Number:	Group Number:

Is this a workers compensation claim? Yes No

Claim #_____

Date of injury_____ Company Name _____

Is this a result of a motor vehicle accident? Yes No

Claim #_____

Date of injury_____ Name of Adjuster_____ Phone #_____

Consent- *By signing below, I give my consent for examination, the performance of any tests deemed necessary, chiropractic care, treatment, or procedures needed. If patient is a minor, by signing I give consent for the above minor patient. I have had a chance to review and clearly understand the risks involved with chiropractic care.*

Patient/Guardian Signature:_____ Date: / /

BODY BALANCE
chiropractic wellness rehabilitation

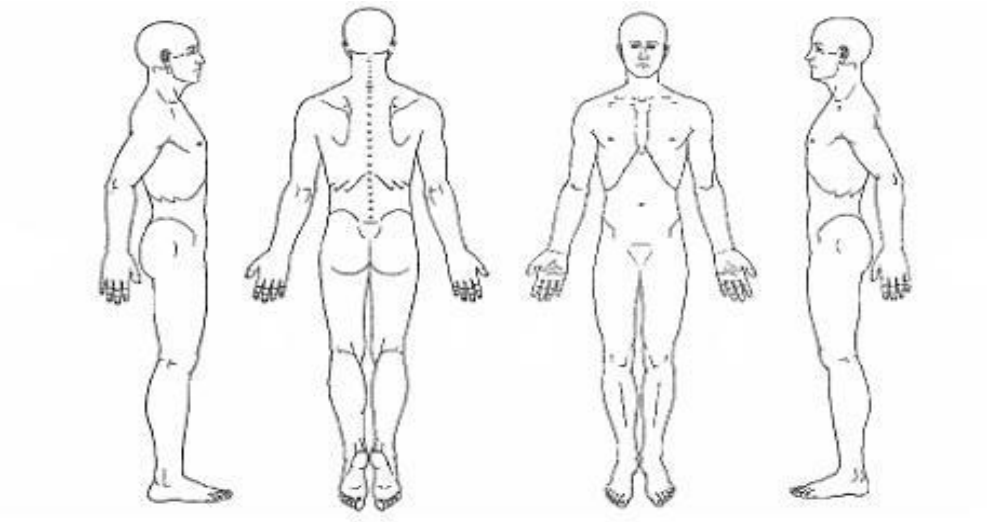
1600 Converse Ave.• Cheyenne, WY 82001
Phone: (307) 632-5901
Fax: (307) 632-4280

Patient Name: _____ **DOB:** _____

PRIMARY COMPLAINT

What is your complaint?_____

PLEASE CIRCLE THE AREAS OF COMPLAINT



When did the discomfort start: _____

Do you know what caused the pain(ex: falling down)?_____

Does the pain radiate or travel(ex: down the leg): No Yes Where to:_____

How often do you experience this symptom: Occasional 25% of time | Intermittent 50% of time | Frequent 75% of time | Constant 100% of time

Choose a number between 0-10 that describes your intensity of pain over the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No pain — Mild — Moderate — Severe

The Pain is: Sharp Dull Aching Burning Tingling Tight Other: _____

Worsened by: Nothing Standing Sitting Lying down Lifting Sleeping Other: _____

Relieved by: Nothing Sleeping Laying Down Sitting Standing Medication Exercise Other: _____

The pain is getting: Worse Better Staying the same

Associated Symptoms: Numbness Tingling Weakness Popping/Clicking Dizziness Other: _____

Are there any changes in: Bowel Bladder Vision Hearing No Changes Other:_____

Have you seen anyone for this condition? No Yes Whom/When:_____

Patient Name: _____ **DOB:** _____

Patient/Guardian Signature:_____ **Date**_____

BODY BALANCE
chiropractic wellness rehabilitation

1600 Converse Ave.• Cheyenne, WY 82001
Phone: (307) 632-5901
Fax: (307) 632-4280

HEALTH HISTORY

Circle Any Conditions You Have Had or Currently Have:

Anemia	Epilepsy	Malaria	Pacemaker	Stroke
Cancer	Gout	Measles	Pleurisy	Tuberculosis
Blood Disorder	Heart Attack	Multiple Sclerosis	Pneumonia	Ulcers
Diabetes	Influenza	Mumps	Polio	Whooping Cough

Are you currently pregnant? Yes No Weeks:_____

Serious Illnesses/Injuries/Hospitalizations:	**Year**	**Current Treatments**
1.		
2.		
3.		
4.		
5.		

Surgeries:

Type _____ Year:_____ Resolved: Y N
Type _____ Year:_____ Resolved: Y N
Type _____ Year:_____ Resolved: Y N
Type _____ Year:_____ Resolved: Y N

X-rays/CT/MRI's: _____

_____

Medications and/or Supplements you are currently taking:	**Reason**
1.	
2.	
3.	
4.	
5.	

If you do not have enough room, please bring a list with you during the next visit so we can make a copy.

Allergies: Seasonal Asthma Animal Dander Latex Penicillin Smoke Grasses Dairy Products

Food: _____ Other: _____

Family Health History: Diabetes Cancer HBP High Cholesterol Heart Disease Disc herniations

Other: _____

Have you seen a chiropractor before? ☐ Yes ☐ No

If yes, how long ago?_____ For what reason? _____ Did it help? Y N

History was obtained from: Patient Spouse Father Mother Other:_____

Patient/Guardian Signature:_____ **Date**_____

BODYBALANCE
chiropractic wellness rehabilitation

1600 Converse Ave.• Cheyenne, WY 82001
Phone: (307) 632-5901
Fax: (307) 632-4280

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Bodybalance, LLC.

I understand that the Notice describes the uses and disclosures of my protected health information by Bodybalance, LLC and informs me of my rights with respect to my protected health information.

_____ **Date of Birth:**_____
Patient Name

_____ **Date:**_____
Signature of patient or legal representative

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____
Employee Name *Today's Date*