BALANCE CHIROPRACTIC

Health Profile

Name_____ Date___/___/___ Age_____ Male/Female

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Cell_____ Date of Birth____/____/_____

Email Address_____ Cell Phone Carrier:_____

For confirming appointments, do you prefer? TEXT or EMAIL

Occupation_____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages & Gender_____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? _____

CHIROPRACTOR? _____ MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN?_____

CIRCLE ANY AND ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
GRATING IN NECK	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*GASTRIC REFULX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	*NAUSEA*
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER*_____
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	_____
STIFFNESS IN NECK	*STOMACH DISORDERS*	*LEG PAINS*	*GERD*	_____
CHRONIC SINUS	*BLADDER PROBLEMS*	*KNEE PAIN*	*ANXIETY*	_____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? _____YES_____NO

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS_____YES ____NO FRACTURED A BONE? ____YES_____NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:_____

SOCIAL HISTORY

1. SMOKING: ❑cigars ❑ pipe ❑ cigarettes ☐ How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. EXERCISE: How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. How does your present problem affect the following: **HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE**

_____

4. WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:

_____

_____

5. What are your Health Goals:

_____

6. Do you know someone else that would benefit from care?

Name:_____ **Phone Number:** _____

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness
S = **S**harp/ **S**tabbing **T**= **T**ingling

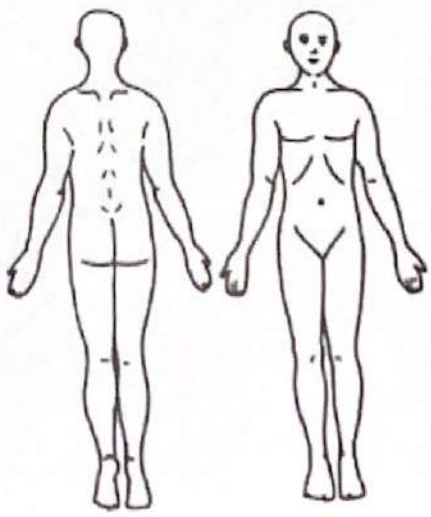
What relieves your symptoms?

_____

What makes them feel worse?

_____

_____



QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 (2) 3 4 (5) 6 7 (8) 9 10 **worst possible pain**

---

1 – What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

Practice Member Information (Must be Completed before Services Can Be Rendered)

NAME: _____

FIRST MIDDLE LAST

PHONE: Home: _____ Cell: _____ Work: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured: _____ Insured Date of Birth: _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation-**includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and /or static palpation, leg checks $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $40-$60.
- **X-Rays-**Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can be used to indicate progress after a period of care. $50 per view.
-

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Erin Magee, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signed_____ Date_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IS ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IS THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PATIENT'S NAME HERE

_____ _____

PATIENT'S SIGNATURE DATE

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. ERIN MAGEE AND ANY AND ALL BALANCE CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. OF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY BALANCE CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR /CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedures applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

I _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVATE PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____
(Signature) (Date)

PLATINUM ID

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS; WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS AND VIDEO FLUOROSCOPY STUDY ON A DISC IS $20.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON AND REGULAR PRACTICE HOUR DAYS.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF PROVIDENCE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVISE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

PRINT YOUR NAME HERE _____ DATE OF BIRTH _____

SIGNATURE _____ DATE _____

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT PROVIDENCE CHIROPRACTIC.

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐F

☐Lat Cervical ☐Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐68	☐1/24	10
☐12-13	☐70	☐1/20	12.5
☐14-15		☐1/15	15
☐16-17		☐1/10	20
		☐2/15	30

MA 300 Size 8x10

☐Cervico-Thoracic

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	5
☐16-17	☐80	☐2/15	7
☐18-19		☐3/20	10
☐20-21		☐2/10	20
☐22-23			

MA 300 Size 8x10

☐APOM

CM	KVP	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17		☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM _____ Kvp_____

MAS _____ MA _____

Size _____

☐Lateral Thoracic

CM	KVP	Time	MAS
☐22-23	☐80	☐1/15	10
☐24-25		☐1/10	20
☐26-27		☐2/15	30
☐28-29		☐2/10	40
☐30-31		☐1/4	50
☐32-33		☐3/10	75
☐34-35		☐2/5	90
☐36-37		☐1/2	120

MA 300 Size 14x17

☐Lateral Lumbar

CM	KVP	Time	MAS
☐26-27	☐80	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31		☐3/10	50
☐32-33		☐2/5	60
☐30-31		☐1/2	75
☐32-33		☐3/5	80
☐34-35		☐4/5	90
☐36-37		☐1	100
☐38-39		☐1 1/5	120
☐40-41		☐2	150
☐42-43			170

MA 200 Size 14x17

☐A-P Thoracic

CM	KVP	Time	MAS
☐16-17	☐75	☐1/20	10
☐18-19	☐80	☐1/15	17
☐20-21		☐1/10	22
☐22-23		☐2/15	30
☐24-25		☐2/10	40
☐26-27		☐1/4	50
☐28-29		☐3/10	75
☐30-31		☐2/5	90

MA 300 Size 14x17

☐A-P Lumbar

CM	KVP	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27		☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	170
☐34-35		☐1/2	210
☐36-37		☐3/5	
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 ½	
		☐2	

MA 200 Size 14x17

Fluoro: 0.25 - _____MA; _____ - _____ kvp; _____secs

Notes: _____

_____

_____

_____

CA Initials _____