

Balance Chiropractic Center

Complete Chiropractic
Care and Wellness

15010 FM 2100, Suite 112 • Crosby, Texas 77532 • 281.462.2500
www.BalanceChiropractic.biz

PATIENT: _____

EXAM DATE: _____

PATIENT INFORMATION

Address _____

CITY

STATE

ZIP

Sex M F Age _____ Birthdate _____

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Single Married Widowed Divorced

Spouse's Name _____

Birthdate _____

SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home _____ Work _____

ACCIDENT INFORMATION

Is condition due to an accident? No Yes Date _____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Workers Comp. Other

Attorney Name (if applicable): _____

INSURANCE

Who is responsible for this account? _____

Subscriber's Name: _____

Birthdate: _____ SS# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. Ryan Konarik 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE

RELATIONSHIP

DATE

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical techniques, on me (or on the patient named below, for whom I am legally responsible) by a doctor of chiropractic named above.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that as with all health care, there are some risks with treatment. Since not all factors of getting well are determined by the Doctor, therefore, specific results cannot be guaranteed

By my (patient's or legal guardian's) signature I acknowledge that I understand the risks of chiropractic treatment and I choose to allow the doctor(s) associated with Balance Chiropractic Center to treat me, or the person for whom I am responsible.

Patient's name (please print)

Signature of Patient

Signature of Parent/Guardian (if patient is a minor)

Signature of Witness

PATIENT CONDITION

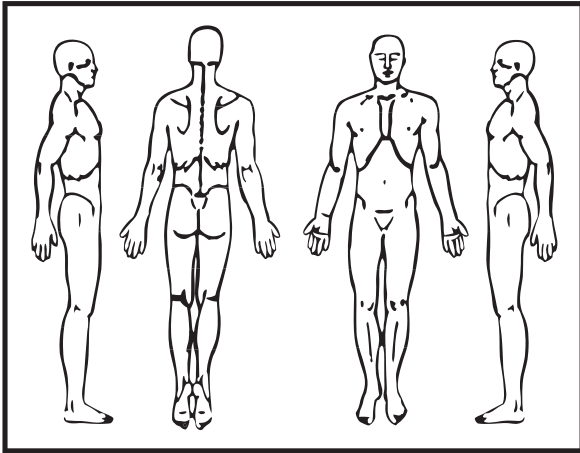
Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse?

Yes No Unknown

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



Rate the severity of your pain on a scale from 1 to 10:

Least Severe 1 2 3 4 5 6 7 8 9 10 Most Severe

Type of pain:

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

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your:

- Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform:

- Sitting Standing Walking Bending
 Lying Down

What treatment have you already received for your condition?

- Medications Surgery Physical Therapy
 Chiropractic Services None Other

Name and address of other doctors(s) who have treated you for your condition _____

Date of Last: Physical Exam _____

Spinal Exam _____

Dental X-Ray _____

Spinal X-Ray _____ Blood Test _____

Chest X-Ray _____ Urine Test _____

MRI, CT-Scan, Bone Scan _____

Indicate if you have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> High Cholesterol | Other _____ |
| <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Liver Disease | _____ |

Are you pregnant Yes No

Expected Date of Delivery: _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Medicines	_____	_____
	_____	_____
Allergies	_____	_____
	_____	_____