

Patient Information

Name _____ Date _____
Preferred Name _____
Address _____
City _____ State _____ Zip _____
Birth Date _____ Patient SSN _____
Sex _____ Age _____ Marital Status _____
Employer _____
Spouse's Name _____ Birth Date _____
Spouse's SSN _____
Employer _____

Phone Numbers

Home _____
Cell _____
Work _____

Emergency Contact

Name _____
Relationship _____
Phone _____
Alt phone _____

Health Insurance

1. Name of Insurance Company _____
Primary Holder _____
Birth Date _____ SSN _____

2. Name of Insurance Company _____
Primary Holder _____
Birth Date _____ SSN _____

Email Address

Primary Doctor Information

Physician Name _____
Phone Number _____

Authorizations

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate.

The patient understands and agrees to allow this chiropractic office to use their PATIENT HEALTH INFORMATION for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PATIENT HEALTH INFORMATION is going to be used in their office and your rights concerning those records. If you would like to have more detailed account of our policies and procedures concerning the privacy of your PATIENT HEALTH INFORMATION we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

I hereby request and CONSET TO CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, including various modes of physical techniques, on me (or the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above. Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am aware that as with all health care, there are some risks with treatment. Since not all factors of getting well are determined by the doctor, 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 doctors and staff associated with Balance Chiropractic Center, LLC. to treat me or the person for whom I am responsible.

Please note it is our office policy we close due to inclement weather in accordance with Crosby ISD.

X _____
Patient/Guardian Signature

Date _____

PATIENT CONDITIONS

Patient Name: _____

Date: _____

1. Area of Pain _____ Pain level 1-10 with 10 worse pain possible _____

Is the pain constant or comes and goes Is the pain getting worse? Yes No

Circle type of pain: Achy Burning Dull Numb Pinching Pulling Shooting Stabbing Stinging Tight Tingling Throbbing

2. Area of Pain _____ Pain level 1-10 with 10 worse pain possible _____

Is the pain constant or comes and goes Is the pain getting worse? Yes No

Circle type of pain: Achy Burning Dull Numb Pinching Pulling Shooting Stabbing Stinging Tight Tingling Throbbing

3. Area of Pain _____ Pain level 1-10 with 10 worse pain possible _____

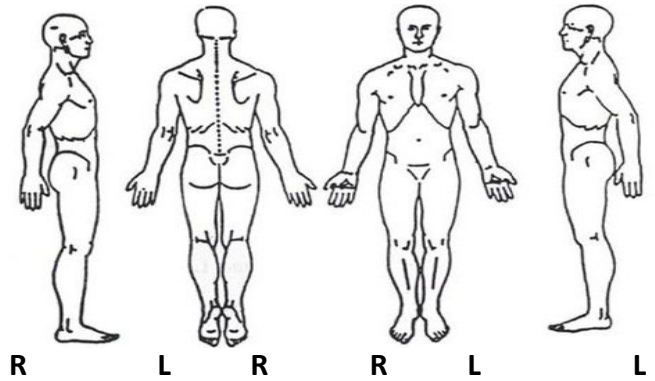
Is the pain constant or comes and goes Is the pain getting worse? Yes No

Circle type of pain: Achy Burning Dull Numb Pinching Pulling Shooting Stabbing Stinging Tight Tingling Throbbing

Very clearly mark on the body chart on the right where the pain, discomfort, numbness or any other feeling that is out of the ordinary. Pay attention to the right and left sides of the body and show any pain that goes from one area to the next.

Example: neck pain traveling down to hand pain.

(shown as a line from neck to hand.)



What caused the pain: Unknown Fall Illness Motor Vehicle Collision Other _____

When did the pain first start: Approximate Month and Year _____

What have you tried to help the pain: Chiropractic Yes No Approximate Month and Year _____

Over the counter medicine: Yes No Prescription Medication Yes No Physical Therapy Yes No

Are you pregnant? Yes No Expected Date of Delivery _____

List any medications you are taking for other health issues: _____

List any exposure to Covid-19: _____

Please indicate, describe & date if you have had any of the following: ****Write "NONE" if you have not****

Falls: _____ Head Injuries: _____

Broken Bones: _____

Dislocations: _____

Surgeries: _____

Patient Signature: _____

(Parent/guardian)

Review of Systems

CONSTITUTIONAL

- Chills
- Drowsiness
- Fainting
- Fatigue
- Fever
- Night sweats
- Weakness
- Weight gain
- Weight loss

EYES

- Blindness
- Blurred vision
- Cataracts
- Change in vision
- Double vision
- Dry eyes
- Eye pain
- Field cuts
- Glaucoma
- Sensitivity to light
- Tearing
- Wears glasses

CARDIOVASCULAR

- Angina
- Chest pain
- Claudication
- Heart murmur
- Heart problems
- High blood pressure
- Low blood pressure
- Orthopnea
- Palpitations
- Shortness of breath
- Swelling of legs
- Varicose veins

RESPIRATORY

- Asthma
- Bronchitis
- Dry cough
- Productive cough
- Coughing up blood
- Difficulty breathing
- Difficulty sleeping
- Hemoptysis
- Pneumonia
- Sputum production
- Wheezing

MUSCULOSKELETAL

- Arthritis
- Neck pain
- Decreased motion
- Gout
- Injuries
- Joint pain
- Joint stiffness
- Locking joints
- Back pain
- Muscle cramps
- Muscle pain
- Muscle twitching
- Muscle weakness
- Swelling

INTEGUMENTARY

- Breast lumps/pain
- Change in nail texture
- Change in skin color
- Eczema
- Hair growth
- Hair loss
- History of skin disorders
- Hives
- Itching
- Paresthesia
- Rash
- Skin lesions

ENMT

- Bad breath
- Dentures
- Deviated septum
- Difficulty swallowing
- Discharge
- Dry mouth
- Ear drainage
- Ear pain
- Frequent sore throat
- Head injury
- Hearing loss
- Hoarseness
- Loss of smell
- Loss of taste
- Nasal congestion
- Nose bleeds
- Post nasal drip
- Sinus infections
- Runny nose
- Snoring
- Sore throat
- Ringing in ears
- TMJ problems
- Ulcers

GASTROINTESTINAL

- Abdominal pain
- Belching
- Black/tarry stool
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice
- Nausea
- Rectal bleeding
- Abnormal stool caliber
- Abnormal stool color
- Abnormal stool consistency
- Vomiting
- Vomiting blood

GENITOURINARY

- Birth control therapy
- Burning urination
- Cramps
- Erectile dysfunction
- Frequent urination
- Hesitancy/dribbling

- Hormone therapy
- Irregular menstruation
- Lack of bladder control
- Prostate problems
- Urine retention
- Vaginal bleeding
- Vaginal discharge

NEUROLOGICAL

- Change in concentration
- Change in memory
- Dizziness
- Headaches
- Imbalance
- Loss of conscience
- Loss of memory
- Numbness
- Seizures
- Sleep disturbance
- Stress
- Strokes
- Tremors

PSYCHIATRIC

- Agitation
- Anxiety
- Appetite changes
- Behavioral changes
- Bipolar disorder
- Confusion
- Convulsions
- Depression
- Homicidal indication
- Insomnia
- Location disorientation
- Memory loss
- Substance abuse
- Suicidal indication
- Time disorientation

ENDOCRINE

- Cold intolerance
- Diabetes
- Excessive appetite
- Excessive hunger
- Excessive thirst
- Goiter
- Hair loss
- Heat intolerance
- Unusual hair growth
- Voice changes

HEMATOLOGIC/LYMPHATIC

- Anemia
- Bleeding
- Blood clotting
- Blood transfusions
- Bruise easily
- Lymph node swelling

ALLERGIC/IMMUNOLOGIC

- History of anaphylaxis
- Itchy eyes
- Sneezing
- Specific food intolerance

SIGNATURE _____

DATE _____