BALANCE
CHIROPRACTIC CENTER
Complete Chiropractic and Massage Care

Dr. Ryan Konarik,D.C.

6314 FM 2100 Crosby, TX 77532
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Patient Information

Name ________________________________ Date ________________
Preferred Name ____
Address ____
City________________________ State___________ Zip____________
Birth Date_________________ SS#___________________________
Sex____________ Spouse's Name_____________________________
Email Address ____
Cell Phone ____

Emergency Contact

Name ___________________________
Relationship _____________________
Phone ___________________________

Primary Doctor Information

Physician Name____________________
Phone Number ____________________

HIPAA & Authorizations

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations.• The practice reserves the right to change the privacy policy as allowed by law.• The practice has the right to restrict the use of the information but the practice does not have to agree to those• restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.• The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
Are there any specific EXCLUSIONS? YES NO
If yes, List: ____

I hereby request and CONSENT 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.

______________________________ ______________________________ ________________

Print Name **Patient/Guardian Signature** **Date**

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

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: Sharp Ache Dull Ache Tension Radiating Numb Swelling Spasm Throbbing Burning Tingling

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: Sharp Ache Dull Ache Tension Radiating Numb Swelling Spasm Throbbing Burning Tingling

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

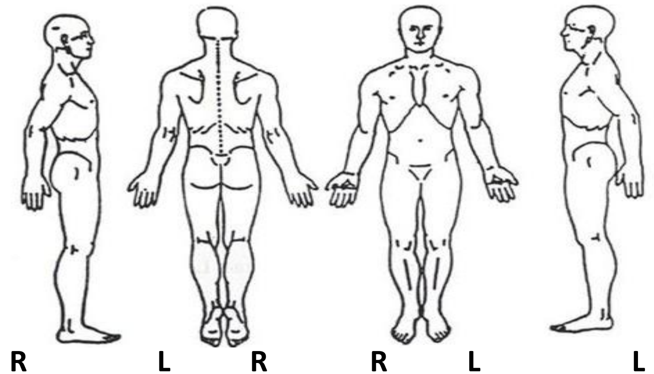
Is the pain ☐ constant or ☐ comes and goes Is the pain getting worse? ☐ Yes ☐ No

Circle type of pain: Sharp Ache Dull Ache Tension Radiating Numb Swelling Spasm Throbbing Burning Tingling

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: ____

____

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)

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Review of Systems

Patient Name: ___________________________________

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

☐ **Deny All**

Signature: ____________________

Date: ________________________