BALANCE POINT CHIROPRACTIC

New Patient

INTAKE FORM

ABOUT YOU

NAME		**NICKNAME**	TODAY'S DATE
EMAIL		DATE OF BIRTH	AGE
HOME ADDRESS		CITY	STATE / ZIP
SS#	☐Male ☐Female	☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED	SPOUSE NAME
YOUR OCCUPATION		EMPLOYER	HOW LONG

HOW DID YOU HEAR ABOUT US? ☐Phone Book ☐Website/Internet ☐Newspaper ☐Referred By: ☐Other:

CONTACT

MOBILE PHONE	HOME PHONE	WORK PHONE
EMERGENCY CONTACT		TELEPHONE#

CIRCLE HOW YOU LIKE TO BE NOTIFIED OF YOUR APPOINTMENTS:

Telephone Email Text message (List carrier)

SELECT ALL THAT APPLY

INS. INFO.

I authorize assignment of my insurance rights & benefits directly to the provider at balance point chiropractic for services rendered.

_____**INITIAL**

Please present insurance card(s) so we can put a copy in your file (Complete Insurance information below if we cannot make a copy of your insurance card)

Co. Name:	Address
Group # (Plan, Local, or Policy #):	Phone Number
Insured's Name:	Date of Birth:
Relationship to Insured	Insured's Employer:

CURRENT COMPLAINT

Location of Problem(s) – PLEASE SELECT ALL THE APPLY

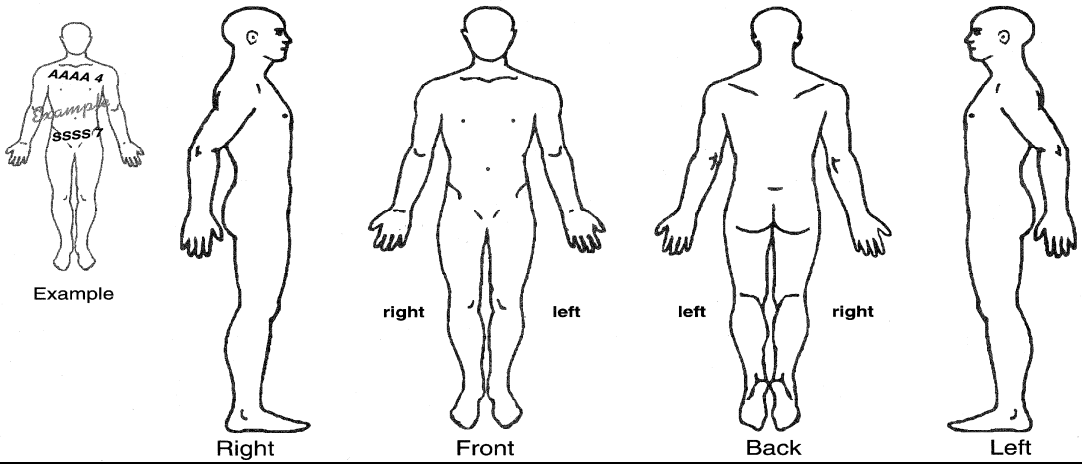
☐ Headaches	☐ Shoulder	☐ Hand	☐ Legs
☐ Jaw	☐ Arm	☐ Mid back	☐ Knee
☐ Neck	☐ Elbow	☐ Low back	☐ Ankle
☐ Upper back	☐ Wrist	☐ Hip	☐ Foot

☐ Other:

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



Pain Intensity Circle One:
1
2
3
4
5
6
7
8
9
10
(Severe)

ACCIDENT

Accident Information

Is you condition due to an accident? ☐ No (skip to next section) ☐ Yes	Date of Accident:
Type of Accident: ☐Automobile ☐Work ☐Home ☐Other	Describe Accident:
Attorney Name (If Applicable):	
Have you reported the accident? ☐Insurance ☐Worker's Comp ☐Employer ☐Other (Describe):	

HEALTH HISTORY

Health History

In general, how do you rate your overall health? ☐ Excellent ☐ Very Good ☐Good ☐ Fair ☐ Poor

Past	Present		Past	Present		Past	Present		Past	Present	
		Headaches			Joint Pain/Stiffness			Bladder Infection			Excessive Thirst
		Neck Pain			Arthritis			Painful Urination			Frequent Urination
		Upper Back Pain			Rheumatoid Arthritis			Loss of Bladder Control			Smoking/Tobacco Use
		Mid Back Pain			Cancer			Prostate Problems			Drug/Alcohol Dependence
		Low Back Pain			Tumor			Loss of Appetite			Allergies
		Shoulder Pain			Asthma			Abdominal Pain			Depression
		Elbow/Upper Arm Pain			Chronic Sinusitis			Ulcer			Systemic Lupus
		Wrist Pain			High Blood Pressure			Hepatitis			Epilepsy
		Hand Pain			Heart Attack			Liver/Gallbladder Disorder			Dermatitis/Eczema/Rash
		Hip Pain			Chest Pains			General Fatigue			HIV/AIDS
		Upper Leg Pain			Stroke			Muscular Incordination			
		Knee Pain			Angina			Abnormal Weight Gain/Loss			**For Females Only**
		Ankle/Foot Pain			Kidney Stones			Visual Disturbances			Birth Control Pills
		Jaw Pain			Kidney Disorders			Dizziness			Hormone Replacement
		OTHER:						Diabetes			Pregnancy

Do you have an immediate family member with any of the following ☐ Rheumatoid arthritis ☐ Hearth problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ ALS ☐ OTHER:

Please list all prescription medications you are currently taking:

Please list all supplements you are currently taking:

Please list all surgical procedures you have had:

Have you had any hospitalizations? ☐ No ☐ Yes (describe) :

Have you had any significant past trauma? ☐ No ☐ Yes (describe) :

Have you seen a chiropractor before? ☐ No ☐ Yes (describe) :

Is there anything else you think we should know? ☐ No ☐ Yes (describe) :

TERMS & CONDITIONS

LEGAL INFORMATION: BY SIGNING BELOW, I AGREE I HAVE READ AND UNDERSTAND THE FOLLOWING

Because bodywork and massage therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the doctor or therapist of all known medical conditions and will keep them updated as to any changes in my medical condition going forward. If I experience any pain or discomfort during a treatment, I will immediately inform the doctor or therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the doctor to release any information required to process insurance claims.

PAYMENT POLICY

We require payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial tech. I understand that if my account is not paid in full within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any expenses incurred in collecting these payments.

NON-SOLICITATION POLICY

I will not solicit, recruit, or encourage any person employed by Balance Point Chiropractic for employment or the provision of services outside of this office.

24 HOUR CANCELLATION POLICY

Should I cancel or miss a massage appointment with less than 24 hours notice, I authorize Balance Point Chiropractic, LLP to charge my VISA/MC/ Discover Card or checking account for the full massage session fee.

E-MAIL POLICY

We will use your e-mail address for appointment reminders, promotions and news from Balance Point Chiropractic, LLP. Your privacy is important to us. We will not sell, rent, or give your name or address to anyone. To unsubscribe, or to receive less or more information, you can select a link at the bottom of every e-mail.

SIGNATURE	I acknowledge that I have received notice of HIPAAP Privacy Practices or have been given the opportunity to review._____(Initial)	DATE	TECH INITIALS
Parent/Guardian Name (If under 18yo)	Relationship to Patient		