



Date: \_\_\_\_\_

# Patient Information

Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Who may we thank for referring you to our office? \_\_\_\_\_

Email address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street/Apt City State Zip

Telephone: Cell \_\_\_\_\_ Work \_\_\_\_\_ Alt. \_\_\_\_\_

May we leave you voicemails regarding your appointments?  Yes  No

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor

Race  Caucasian  African American  Asian  Native American  Latin American  Other \_\_\_\_\_

Ethnicity  Hispanic  Latino  Non-Hispanic / Non-Latino

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel. \_\_\_\_\_

Phone #: (H) \_\_\_\_\_ (W) \_\_\_\_\_

## Accident Information

Is this visit due to an accident?  No  Yes (STOP and see the front desk, we have a different intake for you!)  
If yes, what type?  Auto  Work  Other \_\_\_\_\_

## Insurance Information

Do you have health insurance?  Yes  No Name of Carrier: \_\_\_\_\_

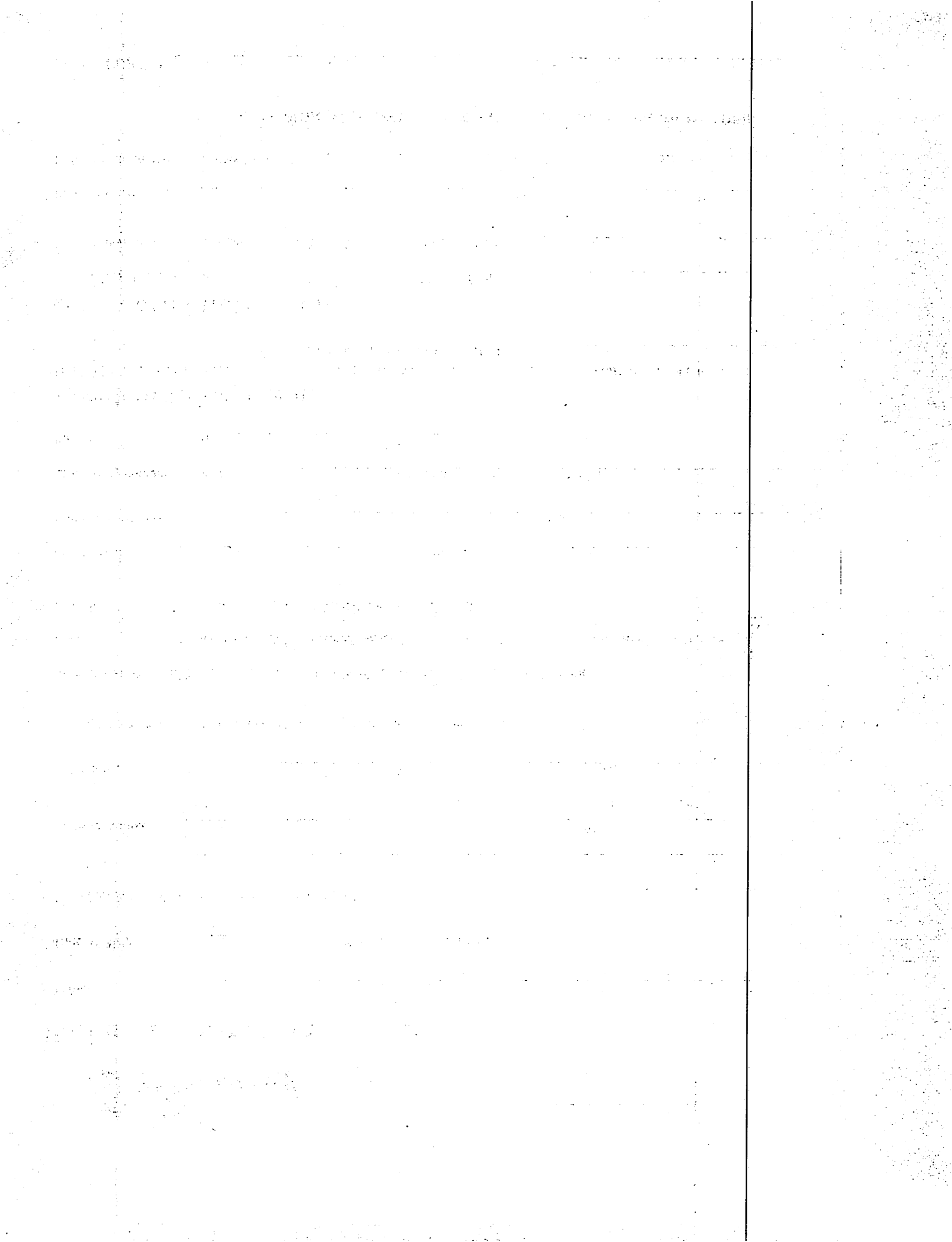
Do you have secondary insurance?  Yes  No Name of Carrier: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ D.O.B. : \_\_\_\_\_

Relationship to patient (if other than self): \_\_\_\_\_ Phone # \_\_\_\_\_

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

SIGNATURE (X) \_\_\_\_\_ DATE \_\_\_\_\_



# Patient Intake

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

- Low Back Pain
- Pain between Shoulder Blades
- Neck Pain
- Tension/Headaches
- Fibromyalgia

- Tension Across Top of Shoulders
- Numbness/Tingling in Arms/Hands
- Numbness/Tingling in Legs/Feet
- Pain in the legs
- Pain in the feet

- Tired/Fatigued
- Difficulty Sleeping
- Allergies
- Digestive Problems
- Carpal Tunnel

Other (Explain) \_\_\_\_\_

Which of the above is the worst? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

What does it feel like? (Describe) \_\_\_\_\_

What have you done that has helped this problem? \_\_\_\_\_

What does this problem prevent you from doing? \_\_\_\_\_

What have you tried to help relieve/get rid of this problem and how much did it help? (Circle)

- Medications | Helped? *Little Some Much*
- Exercise | Helped? *Little Some Much*
- Nutrition | Helped? *Little Some Much*
- Phys. Therapy | Helped? *Little Some Much*
- Chiropractic | Helped? *Little Some Much*

**Does this cause:**

- Moodiness
- Irritability
- Sleep interruptions
- Restriction of Daily Activities

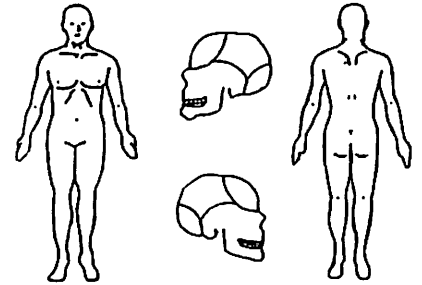
**How does this affect your work?**

- Decreased productivity
- Unable to work long hours
- Exhausted at the end of the day
- Poor attitude
- Decision making

**How does this impact your life?**

- Lose patience with spouse/children
- Difficulty with household duties
- Hinders ability to exercise/play sports
- Interferes with ability to do hobbies

Indicate PRIMARY area of pain/symptoms below:



Are you currently under drug and/or medical care?  Yes  No

If so, who is your primary care physician? \_\_\_\_\_

Would you like for us to share details from today's visit with them?  Yes  No

Please list all current medications, including name, dosage, and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate if you have any immediate family members with any of the following:

- Diabetes
- Cancers
- Lupus
- Rheumatoid Arthritis
- Heart Problems
- ALS

Have you ever been hospitalized? Y/N

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

Please list all current supplements, including name, dosage, and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you've ever had surgery, list procedure(s) and date(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had significant past trauma? Y/N

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Intake of following: Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

Exercise frequency:  Never  Daily  Weekly  Walking  Running  Swimming  Lifting

How would you rate your overall health?  Excellent  Good  Fair  Poor

Please list any known allergies: \_\_\_\_\_

Is there anything else you feel we should know? \_\_\_\_\_

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**Past Medical History and Review of Systems**

| Y   | N   |                                  |
|-----|-----|----------------------------------|
| ___ | ___ | <b>Neurological</b>              |
| ___ | ___ | Migraines                        |
| ___ | ___ | Headaches: how often? _____      |
| ___ | ___ | Slurring of speech               |
| ___ | ___ | <b>Ear/Nose/Throat</b>           |
| ___ | ___ | Altered taste/smell              |
| ___ | ___ | Night Blindness                  |
| ___ | ___ | Sore Throat                      |
| ___ | ___ | Gingivitis                       |
| ___ | ___ | Nose bleeds                      |
| ___ | ___ | <b>Endocrine</b>                 |
| ___ | ___ | Diabetes                         |
| ___ | ___ | Thyroid problems                 |
| ___ | ___ | <b>Cardiovascular</b>            |
| ___ | ___ | High blood pressure              |
| ___ | ___ | High cholesterol                 |
| ___ | ___ | Chest pain                       |
| ___ | ___ | Palpitations-racing heart beat   |
| ___ | ___ | Swelling in hands/feet           |
| ___ | ___ | Anemia                           |
| ___ | ___ | <b>Respiratory</b>               |
| ___ | ___ | Recurrent Respiratory Infections |
| ___ | ___ | Asthma                           |
| ___ | ___ | Chest Congestion                 |
| ___ | ___ | Wheezing                         |
| ___ | ___ | <b>GI</b>                        |
| ___ | ___ | Stomach Pains or Cramping        |
| ___ | ___ | Constipation                     |
| ___ | ___ | Reflux or Heartburn              |
| ___ | ___ | Bloating/Gas                     |
| ___ | ___ | Nausea or Vomiting               |
| ___ | ___ | <b>Musculoskeletal</b>           |
| ___ | ___ | Joint Pain                       |
| ___ | ___ | Arthritis                        |
| ___ | ___ | Chronic pain                     |
| ___ | ___ | Muscle Aches                     |

| Y   | N   |   |
|-----|-----|---|
| ___ | ___ | <b>Skin</b>                                 |
| ___ | ___ | Eczema                                      |
| ___ | ___ | Dermatitis                                  |
| ___ | ___ | Excessive Sweating                          |
| ___ | ___ | Rashes                                      |
| ___ | ___ | Brittle Nails                               |
| ___ | ___ | Hair Loss                                   |
| ___ | ___ | Easy Bruising                               |
| ___ | ___ | Increased Bleeding                          |
| ___ | ___ | Numbness/tingling                           |
| ___ | ___ | <b>Genitourinary</b>                        |
| ___ | ___ | Uterine fibroids                            |
| ___ | ___ | Ovarian cysts                               |
| ___ | ___ | Cancer (breast, ovarian, prostate, uterine) |
| ___ | ___ | Prostate problems                           |
| ___ | ___ | <b>Emotional/Mental</b>                     |
| ___ | ___ | Depression                                  |
| ___ | ___ | Anxiety                                     |
| ___ | ___ | Mood Swings                                 |
| ___ | ___ | Irritability                                |
| ___ | ___ | Memory Loss                                 |
| ___ | ___ | Confusion                                   |
| ___ | ___ | <b>Energy</b>                               |
| ___ | ___ | Fatigue                                     |
| ___ | ___ | Hyperactivity                               |
| ___ | ___ | Restlessness                                |
| ___ | ___ | Insomnia                                    |
| ___ | ___ | Decreased Libido                            |
| ___ | ___ | Stress                                      |
| ___ | ___ | <b>Weight</b>                               |
| ___ | ___ | Decreased Appetite                          |
| ___ | ___ | Weight Gain                                 |
| ___ | ___ | Inability to Lose Weight                    |
| ___ | ___ | Food Cravings                               |
| ___ | ___ | Binge Eating                                |
| ___ | ___ | Water Retention                             |

Medicines previously tried, dosage, duration and outcome.

Advil  Aleve  Tylenol  Steroids  Prescriptions for a period of  0-3mos,  3-6mos,  6-12 mos  12+mos

Please check ALL options you have previously tried to assist in above symptoms:

\_\_\_ Over the counter medications

\_\_\_ Prescriptions

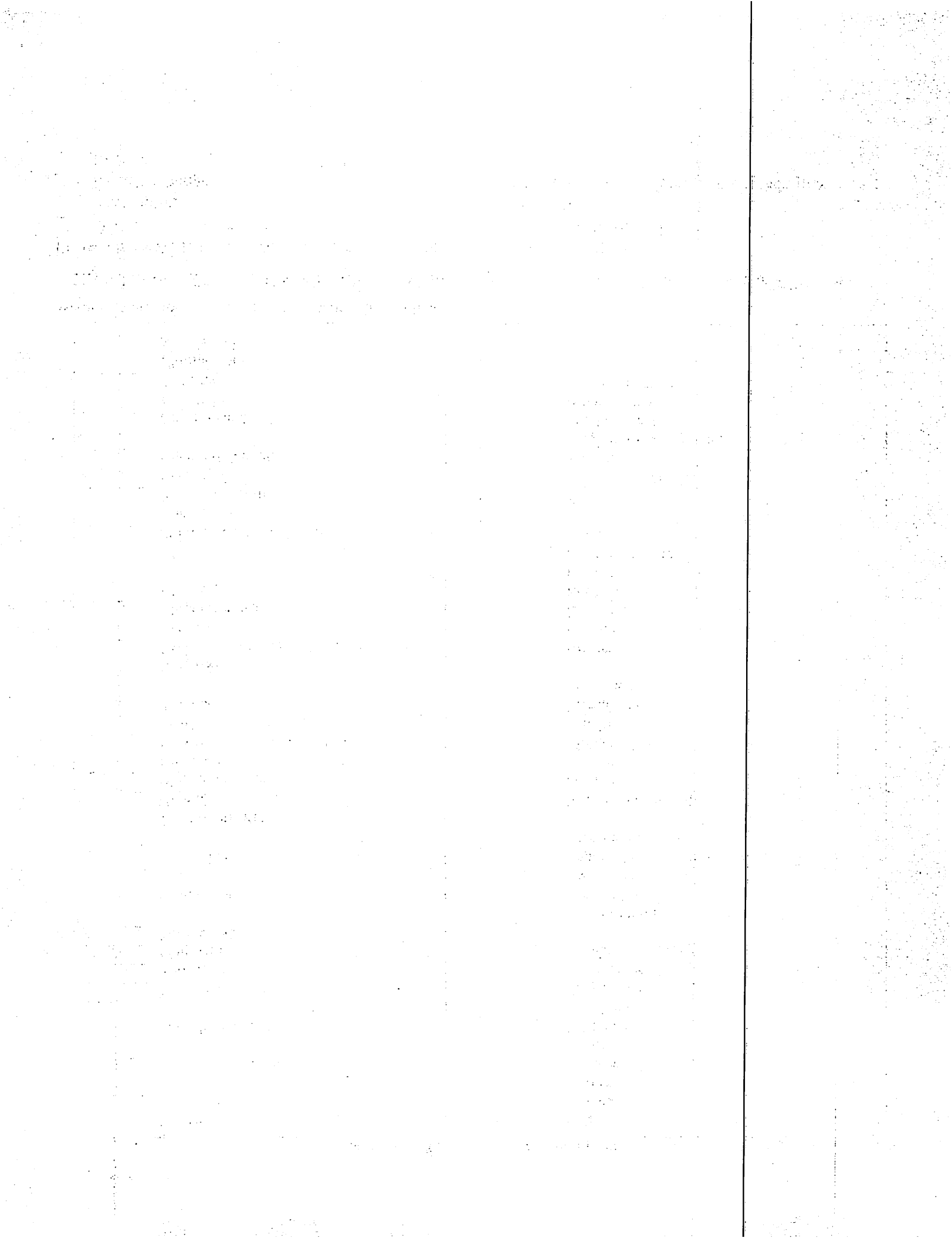
\_\_\_ Dietary Changes

\_\_\_ Exercise

\_\_\_ Consult with specialist

\_\_\_ Supplements

\_\_\_ Alternative medication/treatment therapies



**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
AS WELL AS AN  
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A  
BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Belleview Spine and Wellness, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as BSW) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to BSW for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing BSW as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to BSW all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either BSW, myself, and/or my family members as a result of services rendered by BSW, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that BSW is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that BSW can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Signature of Legal Guardian/Representative (if applicable)

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## **Informed Consent to Care**

**You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.**

**We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.**

**Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.**

**It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.**

**It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.**

*I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I understand that I will receive appointment reminders via text message.*

**Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Witness name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

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# YOUR INSURANCE IS ULTIMATELY YOUR RESPONSIBILITY

To our Valued Patients:

Your copay/co-insurance/deductible payment amount is due and payable at the time of your visit.

Check with your insurance company to determine if authorization is required for your specialist visit and/or procedure.

We must emphasize that as physicians our relationship is with you, not your insurance company. We file claims as a courtesy to our patients. All charges are your responsibility. **NOT** all services we provide are covered by your insurance company. It is important that you read and understand **YOUR** insurance policy and its requirements for coverage.

Private insurance contract between you and your insurance provider. We will **NOT** become involved in disputes between you and your insurance company regarding denials, deductibles, copays, covered charges – usual and customary payments, etc; other than to supply factual information regarding the services rendered, as necessary. If your insurance denies services and/or does not pay for them, you will be responsible for payment on all services provided.

Please sign below stating that you have read, understand, and agree to the above insurance office policy. You, our patient, are ultimately responsible for your own insurance requirements.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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