BACK IN BALANCE
Health and Wellness Center

Patient Information

Today's Date: _____

Name: _____ Age:_____ Date of Birth:_____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone Number:(_____)_____Cell Phone Number: (____)_____

Work Phone Number: (_____)_____ Email: _____

How would you like us to contact you? Home Cell Text Work Email

Status: Single Married Divorced Widowed Sex: Male Female

Social Security Number: _____

Employer: _____ Type of Work: _____

Emergency Contact Person:_____

Emergency Contact Number: (_____)_____

Primary Doctor: _____ Primary Doctor Phone Number:_____

How did you hear about us? _____

Insurance Information

Primary Insurance Company:_____ ID#:_____

Co-Pay Amount:_____ Deductible: Yes No If yes: what is it?_____

Secondary Insurance Company: _____ ID#:_____

Co-Pay Amount:_____ Deductible: Yes No If yes: what is it? _____

How many visits are you allowed? _____

Does your insurance company require an authorization? Yes No

Is this a work related injury? Yes No If yes: Did you fill out a C-3? Yes No

Worker's Compensation Adjuster: _____ Phone Number:_____

Did you file report with your employer? Yes No

Is this an Auto related injury? Yes No If yes: Did you fill out the No Fault Paperwork? Yes No

No Fault Adjuster Name:_____ Phone Number:_____

Current Health Condition

Primary Complaint:_____

When did the problem start? _____

Have you seen another doctor for this problem? Yes No

If yes, Who? _____ When? _____

Did you have X-rays done? Yes No Did you have an MRI done? Yes No

On a scale from 1-10, what is your pain level? _____

Does the pain interfere with:

Work? Yes No Sleep? Yes No Sports? Yes No

Leisure? Yes No Daily Activities? Yes No Other? _____

Are you taking any medications? Yes No

If yes, what are they and how often?

_____
_____
_____

Are you allergic to any medications? Yes No

If yes, what are they and what reaction do you have?

_____
_____
_____

Are you taking any supplements? Yes No

If yes, what are they and how often?

_____

_____

_____

If no, are you interested in learning more about supplements? Yes No

Are you interested in learning more about our weight loss program? Yes No

If yes, what are your current weight loss goals?

_____

_____

Do you exercise? Yes No

If yes, how often and what?

_____

_____

Do you wear or have you worn orthotics? Yes No

If yes, were they custom or over the counter? _____

On a scale from 1- 10, what is your stress level? _____

Does your stress interfere with:

Work? Yes No Sleep? Yes No Sports? Yes No

Leisure? Yes No Daily Activities? Yes No Other? _____

Do you smoke? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Have you had any type of surgeries (past or recent)? Yes No

If yes, please list what it was for and when it was.

What it was for:	When was it:
_____	_____
_____	_____
_____	_____

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Releases

I hereby request and consent to receive chiropractic services, including, but limited to, adjustments, various manual and mechanical procedures, various modes of therapy, for me (or for the patient named below, for whom I am legally responsible) by Dr. MacNaughton who now or in the future treat me. I authorize Dr. MacNaughton and Staff to request medical records as needed from any source.

Initials _____

I clearly understand that all service rendered to me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor's Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

Initials _____

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-Ray, testing, physical findings, diagnosis and prognosis.

Initials _____

If using insurance, I understand that I am responsible for my co-pays, co-insurance, and deductibles that are apart of my insurance plan. I agree to pay for any charges that my insurance company does not see as "medical necessary" or denied charges.

Initials _____

I have read and understood the above information:

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Initial Exam $75.00 Progress Exam $60.00 Adult Adjustment $40.00 Child Adjustment $30.00