First Name:_____ Middle Initial:_____ Last Name:_____

Home Phone #:_____Cell Phone #:_____Work Phone #:_____

Address: _____City: _____

State: _____Zip:_____E-mail Address:
_____ Male / Female

Primary Care Physician Name: _____ Physician Phone Number: _____

Do we have permission to contact your doctor regarding your care in our office? Yes ____ No _____

Check off any of the following symptoms you have experienced in the past 6 months:

O Low Back Pain O Tension Across Top of Shoulders O Tired/Fatigued
O Pain between Shoulder Blades O Numbness/Tingling in Arms/Hands O Difficulty Sleeping
O Neck Pain O Numbness/Tingling in Legs/Feet O Allergies
O Tension/Headaches O Pain in the legs O Digestive Problems O Fibromyalgia Pain in the feet O Carpal Tunnel

OTHER (explain) _____

Have you had any accidents within the past year that affected your symptoms? O Auto O Slip/Fall O Other O None

Which of the above is the worst? _____

How long have you had it? _____

How often does it occur? _____

What does it feel like? (describe) _____

What have you done that has helped this problem? _____

Have you had an accident or injury that is directly related to this problem? _____

_____

Does this cause you to be:	**Does this affect your work:**	**Does this affect your life:**
O Moody	O Decision making	O Lose patience with spouse/children
O Irritable	O Poor Attitude	O Restricted Household Duties
O Interrupt Sleep	O Decrease Productivity	O Hinders ability to exercise or sports
O Restricted in your daily activities	O Exhausted at days end	O Interferes with ability to do hobbies or activities

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

O Medications… Helped: Little Some Much O Exercise... Helped: Little Some Much
O Physical Therapy... Helped: Little Some Much O Nutrition... Helped: Little Some Much
O Chiropractic… Helped: Little Some Much O Stretching... Helped: Little Some Much

OTHER _____

_____

Name:_____ DOB: _____ Date: _____

Occupation: _____Employer: _____

Average # Hours per Week Currently Worked: _____

Type of Tasks Performed/Common Movements: _____

_____

Marital Status: Single Married Divorced Partner Separated Minor

Spouse's Name: _____ # of Children?_____Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Have you had an auto accident? (X if applies): O 0-6mo O 06 mo-l yr O 1-3yrs O 3+yrs O Never

Had a recent fall/other accident? (X if applies): O 0-6mo O 6 mo-l yr O 1-3yrs O 3+Yrs O Never

Have You Ever Received Chiropractic Ca re? O Yes O No Last Visit?

Have you ever Received Physical Therapy? O Yes O No Last Visit?

Do you have Auto insurance? **Yes No** Name of Carrier: _____

Do you have health insurance? **Yes No** Name of Carrier: _____

Do you have secondary insurance? **Yes No** Name of Carrier: _____

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

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, BCI Chiropractic, LLC (D.B.A. Balanced Chiropractic Institute), INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

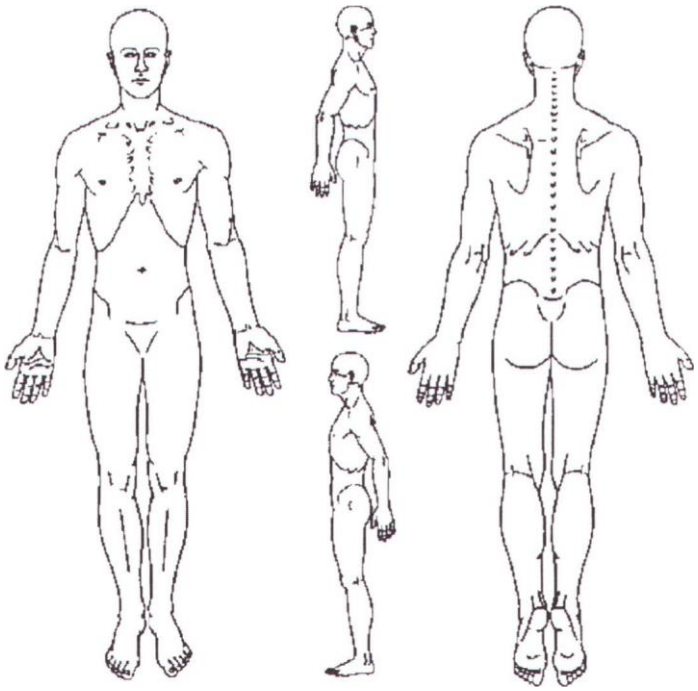
SIGNATURE _____ Date _____

Patient Name_____

PATIENT HEALTH HISTORY

Please check to indicate if you are currently experiencing any of the following conditions and then circle problematic areas on body to right:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Night Pain
- ❑ Depression
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Fainting
- ❑ Dizziness
- ❑ Stomach Problems
- ❑ Asthma
- ❑ Swollen Joints
- ❑ Mood Changes
- ❑ Foot Trouble
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weigh Change
- ❑ Loss of Memory
- ❑ Nausea
- ❑ Loss of Taste
- ❑ Fatigue or Chest Pain
- ❑ Tension
- ❑ Fever
- ❑ Cold Sweats
- ❑ Constipation/Diarrhea
- ❑ Allergies
- ❑ Shortness of Breath
- ❑ Blurred/Double Vision
- ❑ Bowel/Bladder Changes
- ❑ Trouble Concentrating
  Loss of Balance



List any other past history here:_____

_____

_____

_____

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

O There is a possibility that I may be pregnant at this time.

O Yes, I am definitely pregnant

O No, I am definitely not pregnant at this time

O I request that x-ray films not be taken because: _____

_____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

NEUROLOGICAL / MRI / VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please explain under comment and notify Doctor:

Do you suffer from neck pain with pain in your shoulder, arms or hands? **NO YES** Comment:

_____

Do you have weakness, numbness or burning in your shoulder, arms or hands? **NO YES** Comment:

_____

Do your hands or arms fall asleep regularly? **NO YES** Comment: _____

Do you have reduced feeling (sensation) or swelling in your hands or arms? **NO YES** Comment:

_____

Do you suffer from a loss of handgrip strength? **NO YES** Comment:

_____

Do you suffer from back pain with pain in your buttocks, legs or feet? **NO YES** Comment:

_____

Do you have weakness, numbness or burning in your buttocks, legs or feet? **NO YES** Comment:

_____

Do our legs or feet fall asleep regularly? **NO YES** Comment:

_____

Do you have reduced feeling (sensation) or swelling in your legs, **NO YES** Comment:

_____

Do you suffer from cold hands or feet? **NO YES** Comment:

_____

Have you tried any medications such as anti-inflammatory? **NO YES** If yes, what kind of medication?

_____

Have you tried any Physical Therapy or Chiropractic treatments before? **NO YES** If yes: When? For how long? What kind?

_____

Have you had an MRI? **NO YES** If yes: When? Who ordered it? What was it ordered for?

_____

Have you used any splint or braces or other prescribed treatment by an MD? NO YES If yes: When? What kind? Who ordered it? _____

Terms and Acceptance of Service

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, active/passive rehabilitation, chiropractic care, and/or massage therapy. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

The primary focus of care in this office is the detection and correction of Neuromusculoskeletal conditions as well as lifestyle modification for the correction or amelioration of physiological and physical ailments.

Through specific tailored treatment plans, we reduce and/or correct physical or physiological disturbances. It may be necessary to examine an individual each time a new injury occurs and often x-rays, or other diagnostic procedures are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, active/passive rehabilitation, chiropractic care, and/or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the X-rays.

Also, for your protection, portions of our office where patients do not disrobe are under video surveillance, specifically, but not limited to, the front desk check-out stations.

I have read, and I accept the terms above and understand them fully. I hereby give consent to BCI Chiropractic, LLC, to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

I, _____ have read and fully understand the above statements.

_____ _____

(SIGNATURE) (DATE)

FOR MINORS:

I, _____ being the parent or legal guardian of above patient have read and accept the terms and hereby grant permission for my child to receive treatment.

Signature: _____ Date: _____

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW you CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During your care as a patient at BCI Chiropractic, LLC we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive physical medicine care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health-related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

My signature acknowledges that I permit BCI Chiropractic LLC to download and access the prior 13 (Thirteen) months of my medication history through my insurance company.

This notice is effective as of December I, 2011. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Print) _____Signature _____Date_____