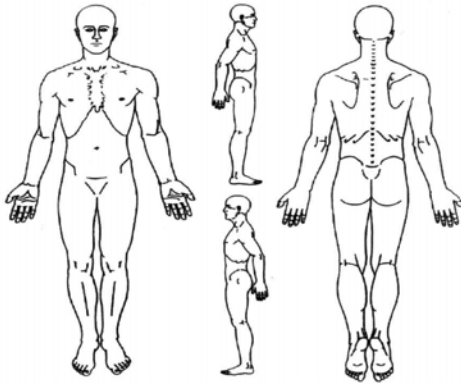


# Welcome to Better Health Through Chiropractic & Massage

Today's Date:		Date of Injury:	
Last Name:		First Name:	Middle Initial:
Address:		City, State, Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Social Security #:	Email:	
Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		How did you hear of us?	Married/Single/Divorced/Widowed
Emergency Contact Name:		Emergency Contact Phone:	
If you have insurance or accident information you wish to use, please give this information to the assistant now.			

## Please mark or color where your concerns are:



- MILD MODERATE SEVERE
- HEADACHES
- NECK PAIN
- BACK PAIN
- LOW BACK PAIN
- HIP OR SHOULDER PAIN
- EXTREMITY PAIN
- SHOOTING / RADIATING / LIGHTENING
- NUMBNESS
- TINGLING / PINS & NEEDLES
- DULL / ACHE PAIN
- SHARP / STABBING

- Your complaints overall cause you:  no impairment  some impairment  marked impairment  prevents activity
- Is this an ongoing issue? No Yes, How long have you experienced? \_\_\_\_\_
- What do you think is causing it? \_\_\_\_\_
- Are you presently under the care of any other doctor? Who? For what?: \_\_\_\_\_
- Have you been involved in a motor vehicle accident within the last 1 year? YES NO
- Have you been involved or are you being treated for a work related injury? YES NO
- Have you been involved in any slip and fall or personal injury claim within the last 1 year? YES NO
- Have you been to a Chiropractor before? How was the experience? \_\_\_\_\_
- Have you ever had a massage before? How was the experience? \_\_\_\_\_
- Are you interested in paying a lower fee for maintenance Chiropractic or massage? YES NO
- Do you have anyone you would like us to contact for a FREE massage? Name & Number: \_\_\_\_\_

## LIST YOUR GOALS YOU WANT FROM CHIROPRACTIC & MASSAGE CARE

1. \_\_\_\_\_
2. \_\_\_\_\_

**Check all conditions that you are CURRENTLY experiencing**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Whiplash                     | <input type="checkbox"/> Loss of balance                 | <input type="checkbox"/> Memory loss                      |
| <input type="checkbox"/> Arthritis/Gout               | <input type="checkbox"/> Sinus congestion                | <input type="checkbox"/> In-coordination                  |
| <input type="checkbox"/> Osteoporosis                 | <input type="checkbox"/> Can't smell                     | <input type="checkbox"/> Loss of strength                 |
| <input type="checkbox"/> Fractures/Dislocations       | <input type="checkbox"/> Jaw/Mouth pain/Clicking         | <input type="checkbox"/> Painful urination                |
| <input type="checkbox"/> Sprains/strains              | <input type="checkbox"/> Chest pain                      | <input type="checkbox"/> Difficult urination              |
| <input type="checkbox"/> Tendonitis/bursitis          | <input type="checkbox"/> Shortness of breath             | <input type="checkbox"/> Change urination frequency       |
| <input type="checkbox"/> Open cuts                    | <input type="checkbox"/> Tuberculosis                    | <input type="checkbox"/> Abnormal night urination         |
| <input type="checkbox"/> Fibromyalgia / Sensitivity   | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Abnormal urine color             |
| <input type="checkbox"/> Prosthesis                   | <input type="checkbox"/> Difficult breathing             | <input type="checkbox"/> Prostate problem                 |
| <input type="checkbox"/> Joint replacements           | <input type="checkbox"/> Breath odor                     | <input type="checkbox"/> Venereal disease                 |
| <input type="checkbox"/> Joint Fusions                | <input type="checkbox"/> Abnormal cough                  | <input type="checkbox"/> Hepatitis A, B, or C             |
| <input type="checkbox"/> High or Low Blood Pressure   | <input type="checkbox"/> Night sweat                     | <input type="checkbox"/> Depression                       |
| <input type="checkbox"/> Fever                        | <input type="checkbox"/> Chest noise                     | <input type="checkbox"/> Bipolar disorders                |
| <input type="checkbox"/> Contagious diseases          | <input type="checkbox"/> Aneurism                        | <input type="checkbox"/> Confusion                        |
| <input type="checkbox"/> Unexplained weight loss      | <input type="checkbox"/> Blood clots                     | <input type="checkbox"/> Hallucinations                   |
| <input type="checkbox"/> Have a cold or flu           | <input type="checkbox"/> Irregular Heart beat            | <input type="checkbox"/> Dementia                         |
| <input type="checkbox"/> Infections                   | <input type="checkbox"/> Pacemaker                       | <input type="checkbox"/> Retardation                      |
| <input type="checkbox"/> Sunburn                      | <input type="checkbox"/> Difficult breathing on exertion | <input type="checkbox"/> HIV/AIDS                         |
| <input type="checkbox"/> Skin rashes/eczema/psoriasis | <input type="checkbox"/> Cold feet/hands                 | <input type="checkbox"/> Rheumatoid disorders             |
| <input type="checkbox"/> Lumps                        | <input type="checkbox"/> Swollen ankle/feet              | <input type="checkbox"/> Autoimmune issues                |
| <input type="checkbox"/> Athletes Foot                | <input type="checkbox"/> Racing heart                    | <input type="checkbox"/> Menstrual irregularity           |
| <input type="checkbox"/> Easy bruise                  | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Excessive menstrual Cramps       |
| <input type="checkbox"/> Varicose Veins               | <input type="checkbox"/> Abdominal pain                  | <input type="checkbox"/> Spotting between periods         |
| <input type="checkbox"/> Unknown spots                | <input type="checkbox"/> Abnormal gas                    | <input type="checkbox"/> Vaginal discharges               |
| <input type="checkbox"/> Concussion                   | <input type="checkbox"/> Nausea / Vomiting               | <input type="checkbox"/> Difficult/unsuccessful pregnancy |
| <input type="checkbox"/> Head injury                  | <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Breast dimpling                  |
| <input type="checkbox"/> Dizzy                        | <input type="checkbox"/> Yellowish eyes/skin             | <input type="checkbox"/> Nipple inversion                 |
| <input type="checkbox"/> Seizures                     | <input type="checkbox"/> Appetite problems               | <input type="checkbox"/> Past abortions                   |
| <input type="checkbox"/> Light sensitive              | <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Trying to get pregnant           |
| <input type="checkbox"/> Blurred Vision               | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Last Period Date _____           |
| <input type="checkbox"/> Double Vision                | <input type="checkbox"/> Hemorrhoids                     | <input type="checkbox"/> Any chance of pregnancy?         |
| <input type="checkbox"/> Ringing ears                 | <input type="checkbox"/> Uncontrolled twitches           | <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <input type="checkbox"/> Hearing loss                 | <input type="checkbox"/> Shakiness                       | <input type="checkbox"/> None                             |

**PAST HISTORY**    DESCRIPTION & YEAR    USE BACK IF NEEDED

Surgeries:

Traumas:

Illnesses:

Medications & Vitamins? Names & Amounts: \_\_\_\_\_

**FAMILY HISTORY**    **Circle:**

Mom:    Deceased    Diabetes    High blood pressure    Cancer    Arthritis    Stroke    Heart

Dad:    Deceased    Diabetes    High blood pressure    Cancer    Arthritis    Stroke    Heart

Siblings: Deceased    Diabetes    High blood pressure    Cancer    Arthritis    Stroke    Heart

**WORK HISTORY**

**Work Name:** \_\_\_\_\_ **Job Description?** \_\_\_\_\_

Does your job involve:     Sitting     Standing     Lifting    How much do you lift consistently? \_\_\_\_\_ lbs     Bending

Twisting     Talking on phone     Computer work     Other:

Has your occupation contributed to your current condition?     Yes     No

**SOCIAL HISTORY**

Highest educational degree obtained? \_\_\_\_\_

Drug use?     Yes     No \_\_\_\_\_    Alcohol use?     Yes     No \_\_\_\_\_    Tobacco use?     Yes     No \_\_\_\_\_

Sleep habits: Hrs/night? \_\_\_\_\_ How?     Right side     Left side     Stomach     Back

Ever been exposed to Poisons/Toxins at home, work, or other?     Yes     No

Exercise/Recreational activities?     Yes     No    What type and how often:

# AUTHORIZATION FOR CARE

## TREATMENT

I have been informed of the nature and purpose of care here, the possible consequences of the care, and the risks of the care, including the risk, that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment. If I experience any pain or discomfort during the treatment, I will immediately inform the doctor or therapist so that treatment levels may be adjusted to my level of comfort. I understand that massage therapists are not qualified to perform manipulations, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of a massage session should be construed as such. Because chiropractic and/or physical therapy should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions asked of me honestly. I agree to keep Better Health Through Chiropractic updated to any changes in my medical profile or personal changes. I further understand that any illicit or sexually suggestive remarks or advances made by me to the employees of Better Health Through Chiropractic shall result in immediate termination of the treatment session and I will be completely liable for payment of the scheduled treatment.

## YOUR INSURANCE

I understand that insurance benefits, eligibility and pre-certification information is not a guarantee of coverage or payment. I understand that a guarantee of coverage and benefits can only be obtained once the insurance company sends response to the submitted claim. I hereby authorize and assign payment from the insurance I wish to use, directly to Scott M. Johnson, D.C. and BHTC for professional services rendered. I hereby authorize the attending doctor to release any and all information concerning my examination or statement for purposes of satisfying these bills. I also agree to pay all charges and/or co-payments at the time of service. If, before, during, or after the time of treatment in this office, your insurance coverage is found to be less than or different than first believed, told with pre-certification, or nonexistent, then I understand that I am responsible for payment in full of any unpaid services and fees. I understand that should, by any reason or inadvertency, any payment of check come directly to me from these insurance(s), that I am not entitled to keep said check, but should pay it directly to *Better Health Through Chiropractic* within 10 days of receipt or incur a 10% fee every month of delinquency.

## DELINQUENT ACCOUNTS

Full patient responsibility payment is expected at the time of service. At 30 days after the date of service, any outstanding balance is considered an "accounts receivable" and is in default of this agreement. A \$45 late fee will be assessed and collection of this debt will be turned over to an accounts receivables collection company hired on behalf of Better Health Through Chiropractic. Phase I collections occurs past 30 days delinquent. If a delinquent account enters Phase II there is an additional 50% of the debt fee charged to Better Health Through Chiropractic for the collection of this debt. I understand these fees are incurred by this office for the collection of appropriately billed services rendered. If this account should go into default I understand that I will be held liable for all collection fees, court fees, and attorney fees incurred to collect this debt. In addition, I understand and accept that *Better Health Through Chiropractic* does not reduce bills, remove performed services from bills, or write-off portions of bills especially for the purpose of conforming to fit within an insurance settlement, payment, or attorney disbursement. I further understand and accept that I am liable for any outstanding balance after an insurance or attorney disbursement.

This, or a photocopy, will also serve as an authorization for release of emergency department, urgent care and/or medical records which may be necessary in my medical care or any insurance company with which I have a contractual agreement.

**I HAVE READ AND AGREE TO THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS THAT I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE BETTER HEALTH THROUGH CHIROPRACTIC & MASSAGE TO PROCEED WITH EXAMINATION AND TREATMENT.**

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## IF PATIENT IS A MINOR OR UNABLE TO CONSENT:

Age: \_\_\_\_\_ or reason patient is unable to consent: \_\_\_\_\_

Person authorized to sign for the patient, print name and relationship: \_\_\_\_\_

**CIRCLE THE BEST FIT FOR EACH CATEGORY WITH YOUR CONDITION:**

<p><b>My Pain is:</b> <span style="float: right;"><i>C/L</i></span></p> <p>A None          B Mild.          C Moderate          D Fairly Severe          E Very Severe          F Unbelievable/Unimaginable pain</p>	<p><b>Walking is:</b> <span style="float: right;"><i>L</i></span></p> <p>A. No problem.          B. Walking hurts me          C. Can't/don't want to walk more than 1 mile.          D. Less than ¼ mile.          E. Only with cane or crutches or support.          F. I cannot walk. I have to crawl or be carried to get to the toilet.</p>
<p><b>Dressing and washing myself is:</b> <span style="float: right;"><i>C/L</i></span></p> <p>A Not painful.          B Normal but with pain.          C It hurts and slows me down.          D I need some help          E I need a lot of help          F I do not get dressed, I am sponge bathed</p>	<p><b>Work aggravates my pain:</b> <span style="float: right;"><i>C/L</i></span></p> <p>A None.          B It hurts me          C I can do most of my work but not all          D Only half my work.          E I've had to change my job position.          F I cannot do any work at all.</p>
<p><b>Pain affects my concentration:</b> <span style="float: right;"><i>C</i></span></p> <p>A None          B Some          C A bit          D A lot          E A whole lot          F I cannot concentrate at all due to pain</p>	<p><b>Driving is:</b> <span style="float: right;"><i>C/L</i></span></p> <p>A No problem          B Slightly painful          C Moderately painful and or restriction.          D I cannot drive my car as long as I want due to pain          E Causes severe pain and restriction          F I cannot drive my car at all.</p>
<p><b>Reading causes me:</b> <span style="float: right;"><i>C</i></span></p> <p>A No problem          B Slight pain.          C Moderate pain.          D To not read as much as I want.          E Severe pain.          F I cannot read at all due to pain</p>	<p><b>Sleeping is interrupted:</b> <span style="float: right;"><i>C/L</i></span></p> <p>A None          B Less than 1 hour sleepless          C 1-2 hours sleepless          D 2-3 hours sleepless          E 3-5 hours sleepless          F 5-7 hours</p>
<p><b>Headaches are:</b> <span style="float: right;"><i>C</i></span></p> <p>A None at all.          B Slight &amp; infrequent          C Moderate &amp; infrequent          D Moderate &amp; frequent          E Severe &amp; frequent          F Severe all the time</p>	<p><b>Recreation activities are: (What you do when not working)</b> <span style="float: right;"><i>C/L</i></span></p> <p>A No problem          B Increases pain          C I can't do some things.          D I can only do a few things          E I can hardly do anything.          F I cannot do any recreational activities at all.</p>
<p><b>Standing is:</b> <span style="float: right;"><i>L</i></span></p> <p>A No problem          B. Increases pain.          C. Can't stand for more than 1 hour.          D. Can't for more than 30 minutes.          E. Can't for more than 10 minutes.          F. Pain prevents me from standing at all.</p>	<p><b>Lifting weights is:</b> <span style="float: right;"><i>C/L</i></span></p> <p>A Normal, no pain          B Increases pain          C Has to be conveniently positioned          D Only light to medium weights.          E Only very light weights.          F I cannot lift or carry anything.</p>
<p><b>Sitting is:</b> <span style="float: right;"><i>L</i></span></p> <p>A No problem          B. Increases pain          C. Can't sit for more than 1 hour.          D. Can't for more than 30 minutes.          E. Can't for more than 10 minutes.          F. Pain prevents me from sitting at all.</p>	<p><u>Administrative Use Only</u></p> <p>Date _____ NeckADL _____ LowbackADL _____</p>