Backbone, LLC

PATIENT INFORMATION

LAST NAME ______________________ FIRST ______________________ MIDDLE INITIAL ______ ☐ M / ☐ F

ADDRESS ______________________ AGE ________ BIRTH DATE_____/______/_____

CITY ______________________ STATE ___________ ZIP __________

PHONE: HOME ______________________ CELL ______________________ WORK ______________________

EMAIL ______________________ SOCIAL SECURITY NUMBER: _________-_______-_________

MARITAL STATUS ______________ NUMBER & AGES OF CHILDREN ______________________

EMPLOYER ______________________ TYPE OF WORK ______________________

HOW DID YOU HEAR OF US? (PLEASE CHECK ALL THAT APPLY) ☐ NEWSPAPER ☐ PHONE BOOK ☐ CHAMBER OF COMMERCE

☐ INTERNET: SEARCH TERM? ______________________ ☐ REFERRAL: WHO MAY WE THANK? ______________________

WHO IS YOUR MEDICAL DOCTOR OR PRIMARY PHYSICIAN? ______________________

WOULD YOU LIKE US TO SHARE OUR FINDINGS WITH HIM/HER? ☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION

NAME______________________ RELATIONSHIP ____________PHONE______________________ CELL / HOME / WORK

PURPOSE OF THIS VISIT: ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ NOT RELATED

1ST COMPLAINT: ______________________ **WHEN DID IT START?** ______________________

HOW BAD IS THIS PAIN? ☐ MILD ☐ MODERATE ☐ SEVERE ☐ INTOLERABLE

HOW DO YOU DESCRIBE THE PAIN? ☐ ACHE ☐ DULL ☐ SORE ☐ SHOOTING ☐ TINGLING ☐ NUMB ☐ BURNING ☐ STABBING

HOW MUCH OF THE DAY DO YOU FEEL IT? ☐ 76-100% ☐ 51-75% ☐ 26-50% ☐ 0-25%

WHAT MAKES IT BETTER? ______________________ **WORSE?** ______________________

2ND COMPLAINT: ______________________ **WHEN DID IT START?** ______________________

HOW BAD IS THIS PAIN? ☐ MILD ☐ MODERATE ☐ SEVERE ☐ INTOLERABLE

HOW DO YOU DESCRIBE THE PAIN? ☐ ACHE ☐ DULL ☐ SORE ☐ SHOOTING ☐ TINGLING ☐ NUMB ☐ BURNING ☐ STABBING

HOW MUCH OF THE DAY DO YOU FEEL IT? ☐ 76-100% ☐ 51-75% ☐ 26-50% ☐ 0-25%

WHAT MAKES IT BETTER? ______________________ **WORSE?** ______________________

3RD COMPLAINT: ______________________ **WHEN DID IT START?** ______________________

HOW BAD IS THIS PAIN? ☐ MILD ☐ MODERATE ☐ SEVERE ☐ INTOLERABLE

HOW DO YOU DESCRIBE THE PAIN? ☐ ACHE ☐ DULL ☐ SORE ☐ SHOOTING ☐ TINGLING ☐ NUMB ☐ BURNING ☐ STABBING

HOW MUCH OF THE DAY DO YOU FEEL IT? ☐ 76-100% ☐ 51-75% ☐ 26-50% ☐ 0-25%

WHAT MAKES IT BETTER? ______________________ **WORSE?** ______________________

HOW DO YOU WANT US TO HANDLE YOUR PROBLEMS?

☐ ACUTE CARE ONLY – SYMPTOM RELIEF IS MY ONLY CONCERN.

☐ CORRECTION – I WANT RELIEF AND TO CORRECT THE CAUSE OF THE PROBLEM FOR MAXIMUM STABILITY IN THE FUTURE.

This document contains Protected Health Information and may not be shared without proper authorization.
©2010-2017, All Rights Reserved

Backbone, LLC

PATIENT NAME ______________________________ DATE______________

PLEASE MARK EVERYTHING YOU ARE EXPERIENCING **NOW** OR HAVE **IN THE PAST SIX (6) MONTHS**

☐ CHECK HERE IF YOU HAVE HAD ABSOLUTELY NO SYMPTOMS IN THE LAST 6 MONTHS

NECK RELATED:

- ☐ NECK PAIN / STIFFNESS
- ☐ HEADACHE / MIGRAINE
- ☐ NUMB / TINGLING IN ARMS / HANDS
- ☐ PAIN IN ARMS / HANDS
- ☐ COLDNESS IN HANDS
- ☐ WEAKNESS IN GRIP
- ☐ CARPAL TUNNEL
- ☐ FIBROMYALGIA
- ☐ LOW ENERGY / FATIGUE
- ☐ HEARING DISTURBANCES
- ☐ VISUAL DISTURBANCES
- ☐ DIZZINESS
- ☐ TMJ / JAW PAIN OR CLICKING
- ☐ ALLERGIES / HAY FEVER
- ☐ SINUSITIS
- ☐ RECURRENT COLDS / FLU
- ☐ LOW THYROID
- ☐ DIFFICULTY CONCENTRATING

MID-BACK RELATED:

- ☐ PAIN BETWEEN SHOULDER BLADES
- ☐ MID-BACK PAIN / STIFFNESS
- ☐ PAIN IN RIBS / CHEST
- ☐ TENSION IN SHOULDERS
- ☐ INDIGESTION / HEARTBURN
- ☐ REFLUX
- ☐ ULCERS / GASTRITIS
- ☐ HEART MURMURS
- ☐ DIABETES
- ☐ HYPOGLYCEMIA
- ☐ HEART ATTACKS / ANGINA
- ☐ HEART PALPITATIONS
- ☐ RAPID HEART BEAT
- ☐ TIRED OR IRRITABLE AFTER EATING OR IF HAVEN'T EATEN FOR A WHILE
- ☐ NAUSEA
- ☐ SHORTNESS OF BREATH
- ☐ ASTHMA / WHEEZING
- ☐ LUNG INFECTIONS / BRONCHITIS
- ☐ PAIN ON DEEP BREATHING

LOW BACK RELATED:

- ☐ LOW BACK PAIN / STIFFNESS
- ☐ PAIN IN HIPS / LEGS / FEET
- ☐ NUMBNESS / TINGLING IN LEGS / FEET
- ☐ COLDNESS IN FEET
- ☐ WEAKNESS IN LEGS
- ☐ MENSTRUAL IRREGULARITIES / CRAMPING
- ☐ INJURIES IN HIPS / KNEES / ANKLES
- ☐ MUSCLE CRAMPS IN LEGS / FEET
- ☐ BLADDER INFECTIONS
- ☐ FREQUENT / DIFFICULTY URINATING
- ☐ SEXUAL DYSFUNCTION
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ IRRITABLE BOWEL
- ☐ CROHN'S DISEASE
- ☐ OSTEOPOROSIS

ANY CONDITION NOT LISTED ABOVE ______________________________

PLEASE LIST ALL MEDICATIONS **PRESCRIBED** OR **OVER THE COUNTER**: ☐ **CHECK HERE IF YOU TAKE NO MEDICATIONS**

MEDICATION ____________________ PRESCRIBED FOR ____________________

MEDICATION ____________________ PRESCRIBED FOR ____________________

MEDICATION ____________________ PRESCRIBED FOR ____________________

OTHER MEDICATION: ______________________________

PAST HISTORY OF ILLNESS OR INJURY

PLEASE LIST **ALL SURGERIES**, **FALLS**, OR **INJURIES**: ☐ **NO SURGERIES** ☐ **NO FALLS** ☐ **NO INJURIES**

SURGERY ______________________________ DATE ____________

SURGERY ______________________________ DATE ____________

FALL / INJURY ______________________________ DATE ____________

FALL / INJURY ______________________________ DATE ____________

OTHER SURGERY, FALLS, INJURIES ______________________________

HAVE YOU EVER HAD A CONCUSSION? ☐ NO ☐ YES, WHEN? ____________________

DOCTOR'S NOTES: ______________________________

____

This document contains Protected Health Information and may not be shared without proper authorization.
©2010-2017, All Rights Reserved

Last modified 11-17-2017

Backbone, LLC

PATIENT NAME ______________________________ DATE______________

SOCIAL HISTORY & HEALTH HABITS

DO YOU:

USE ANY TOBACCO: CIGARETTES / CIGARS / CHEW: ☐ NEVER ☐ YES ☐ QUIT ______ MONTHS/YEARS AGO

CONSUME WINE, BEER, OR ALCOHOL:
☐ MORE THAN 3 PER WEEK ☐ SOCIALLY OR ON THE WEEKENDS ☐ ALMOST NONE ☐ NONE

EXERCISE? ☐ 3+ DAYS/WK ☐ 1-2 DAYS/WK ☐ NONE ☐ VERY PHYSICAL JOB

DRINK WATER DAILY? ☐ AT LEAST 8 CUPS ☐ SOME BUT NOT ENOUGH ☐ LITTLE TO NONE

EAT WELL? ☐ GREAT ☐ AVERAGE ☐ POOR ☐ TOO MUCH SUGAR

WOULD YOU BE INTERESTED IN AN EASY WAY TO INCREASE YOUR RAW FRUIT AND VEGETABLE INTAKE? ☐ YES ☐ NO

TAKE VITAMINS, MINERALS, HERBS, OR OTHER SUPPLEMENTS? ☐ NONE

WHAT KIND ____________ AMOUNT __________ PRESCRIBED? ☐ NO ☐ YES ☐ FOR ________
WHAT KIND ____________ AMOUNT __________ PRESCRIBED? ☐ NO ☐ YES ☐ FOR ________
WHAT KIND ____________ AMOUNT __________ PRESCRIBED? ☐ NO ☐ YES ☐ FOR ________
WHAT KIND ____________ AMOUNT __________ PRESCRIBED? ☐ NO ☐ YES ☐ FOR ________
OTHER: ____

FAMILY HISTORY

☐ CHECK HERE IF **UNKNOWN** OR **NO FAMILY HISTORY** OF DIABETES, CANCER, HEART DISEASE, OR OTHER ILLNESS.

MOTHER'S SIDE OF FAMILY:

MOTHER	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________
GRANDMOTHER	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________
GRANDFATHER	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________

FATHER'S SIDE OF FAMILY:

FATHER	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________
GRANDMOTHER	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________
GRANDFATHER	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________

#____ BROTHERS:	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________
#____ SISTERS:	☐ DIABETES	☐ CANCER	☐ HEART DISEASE	☐ OTHER ____________

DOCTOR'S NOTES:

____
____
____

This document contains Protected Health Information and may not be shared without proper authorization.
©2010-2017, All Rights Reserved

Backbone, LLC

Financial/Office Policies ~ Assignment and Release

For Patient: ______________________________

In order to provide you and/or your family members with the highest quality of Chiropractic spinal health care we ask that you please comply with our policies described below:

I understand that when appointments are made, time is set aside for me with the doctor. We ask that you please give 24 hours notice if you are unable to keep your scheduled appointment.

Although services may be covered by my insurance, I understand that I am fully responsible for my account. Coverage and benefits are a contract between the insurance company and me. Any billing to an insurance company on your behalf is a courtesy by this office.

Regardless of the insurance coverage, I am responsible for payment on my account. Although the office staff will gladly assist me with my insurance, I am also responsible to check with my insurance company regarding the type of coverage and benefits offered within my policy.

All accounts may be subject to a 1.5% monthly finance charge on the unpaid balance after 60 days. I agree to waive my confidentiality for collection purposes only.

Assignment & Release (Please select the appropriate box).

☐ I am self-pay (cash, check, or credit card).

OR

☐ I and/or my dependent(s) have insurance coverage with ______________________________ insurance company. I assign all policy benefits directly to Backbone, LLC. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above named business may use my health information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services, determining insurance benefits, or the benefits payable for related services. This consent is valid until all balances are satisfied or revoked in writing. I attest that the information I provided is correct to the best of my knowledge. I will not hold Backbone, LLC responsible for any errors or omissions that I may have made in the completion of my paperwork.

I, ______________________, have read and understand the above assignment & release. By signing below, I agree to
(print name)
abide by the financial/office policies.

Signed: ______________________________ *Date:* ____________________

Assignment & Release for a minor child:

I, ________________________, being the parent/legal guardian of _______________________________, agree to abide by the financial/office policies listed.

_______________________________________ ________________
Signature of parent/legal guardian Date

This document contains Protected Health Information and may not be shared without proper authorization.
©2010-2017, All Rights Reserved

Backbone, LLC

Disclosure & Consent for Chiropractic Adjustments, Laser, & Rehabilitation Care

For Patient: ___________________________________

You have the right as a patient to be informed about your condition and the recommended treatment to be used so you can make an informed decision about the procedures after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed you so you may give or withhold your consent to the procedures.

Please continue to follow your other doctor's orders (meds, etc.). We can NOT prescribe reduction in medication and will not interfere with another doctor's treatment. If you feel your medication needs to be modified, please contact the doctor who prescribed them. We are happy to work together with your other health care providers toward the restoration and maintenance of your health.

☐ I hereby request an evaluation of my spine/injuries at the discretion of the doctor. I understand that I will be informed after the examination if x-rays are indicated and necessary. X-rays may be a critical tool in evaluating injuries and assessing appropriateness of adjusting and rehabilitation.

☐ I will have the opportunity to discuss with the Doctor my evaluation results and diagnosis, the nature and purpose of chiropractic adjustments, rehabilitation, and laser therapy and the progression of my condition both with and without care.

☐ I understand and am informed that there are some risks to exam and treatment, including, but not limited to, sprain/strain, frostbite, burn, fracture, disc injury, dislocation, increased pain or symptom, new pain or symptoms may be uncovered, blood clot disruption, strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of treatment which, based on the facts known then, is in my best interest. I further acknowledge that no promises or guarantees, stated or implied, have been made concerning the results intended from the treatment.

☐ I consent to the performance of chiropractic adjustments, rehabilitation, and laser therapy on me by the Chiropractor, the staff (as appropriate/allowed by law), or another Chiropractor working in the clinic now or in the future.

I, ______________________, have read and understand the above consent. By signing below, I consent to the
(print name)
treatment that the Chiropractor deems to be in my best interest. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signed: ______________________________ *Date:* ____________________

Consent to evaluate and treat a minor child:

I, ______________________, being the parent/legal guardian of _______________________________, have read and fully understand the above terms and grant permission for my child to receive chiropractic care.

_______________________________________ ________________
Signature of parent/legal guardian Date

WOMEN:
Pregnancy Release:
This is to certify that to the best of my knowledge, I am not pregnant. The above Chiropractors and/or associates have my permission to perform an x-ray evaluation. I have been advised that x-rays may be hazardous to an unborn child.

Date of last menstrual period: ___________________

_______________________________________ ________________
Signature Date

This document contains Protected Health Information and may not be shared without proper authorization.
©2010-2017, All Rights Reserved