Back to Health Chiropractic ◆ 3075 West 7800 South, West Jordan UT 84088 ◆ 801 565-9500

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Social Security #: _____-____-_____ Home phone : _____

Address: _____ Cell Phone: _____

Best telephone number to reach you during the day: ☐ Cell ☐ Work ☐ Home ☐ Other: _____

Email: _____ Age: _____ DOB: _____ Height: _____ Weight: _____ Sex: ☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ W ☐ D How many Children: _____ Referred to our office by: _____

Occupation: _____ Employer: _____ Phone: _____

Spouse Name: _____ Employer:_____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Health History

Main symptom(s) you feel: _____ Average Pain Level: 0-10 (10 being worst) _____

What caused your condition: ☐ Auto Accident ☐ Work Accident ☐Overexertion, Lifting Pulling, Etc.

☐ Repetitive Movement/Posture ☐ Fall/Trip/Slip Where? ☐ Gradual Onset ☐ Other _____

Date symptom(s) appeared: _____ Are symptoms: ☐ Better ☐ Worse ☐ Same

Have you seen a doctor about this? ☐ Y ☐ N Name: _____ When: _____

Have you had or do you currently have: ☐ Neuropathy ☐ Strokes ☐ Fainting Spells ☐ Back Surgery

Do you have any family history of: ☐ Back Pain ☐ Arthritis ☐ Headaches ☐ Diabetes

Do you smoke: ☐ Y ☐ N _____ packs per day. Do you drink alcohol: ☐ Y ☐ N _____ times per week.

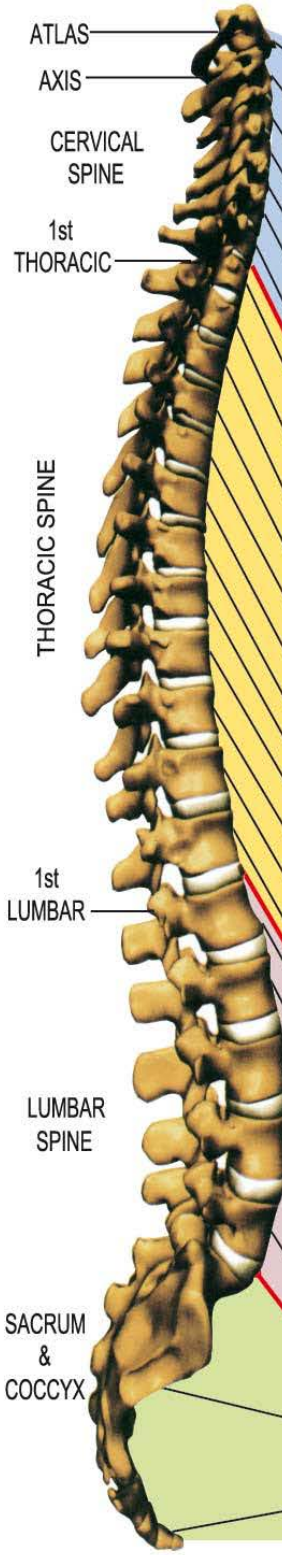
Injuries or surgeries: _____ Dates: _____

Current medications: _____ Are you pregnant: ☐ Y ☐ N

The information I have provided is accurate and I know it will be used to determine appropriate chiropractic care. I authorize the performance of X-rays and all of their diagnostic and therapeutic procedures for myself and/or for my dependent(s). I acknowledge receipt of the Notice of Privacy Practices. I also give my consent to receive important email correspondence from this office.

Signature of responsible party: _____ Date: _____

system which could affect the structures, organs, and functions listed under “areas” and the “possible symptoms” that are associated with malfunctions of the areas noted.



Vertebrae	Areas & Parts of Body	Possible symptoms
C1	Blood supply to the head, pituitary gland scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	❑ Headaches ❑ nervousness ❑ insomnia ❑ head colds ❑ high blood pressure ❑ migraine headaches ❑ nervous breakdowns ❑ amnesia ❑ chronic tiredness ❑ dizziness
C2	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	❑ Sinus trouble ❑ allergies ❑ pain around the eyes ❑ earache ❑ fainting spells ❑ certain cases of blindness ❑ crossed eyes ❑ deafness
C3	Cheeks, outer ear, face bones, teeth, trifacial nerve.	❑ Neuralgia ❑ neuritis ❑ acne or pimples ❑ eczema
C4	Nose, lips, mouth, eustachian tube.	❑ Hay fever ❑ runny nose ❑ hearing loss ❑ adenoids
C5	Vocal cords, neck glands, pharynx.	❑ Laryngitis ❑ hoarseness ❑ throat conditions such as sore throat or quinsy
C6	Neck muscle, shoulders, tonsils.	❑ Stiff neck ❑ pain in upper arm ❑ tonsillitis ❑ chronic cough ❑ croup
C7	Thyroid gland, bursae in the shoulders, elbows.	❑ Bursitis ❑ colds ❑ thyroid conditions
T1	Arms from the elbows down, including hands, wrists, and fingers, esophagus and trachea.	❑ Asthma ❑ cough ❑ difficult breathing ❑ shortness of breath ❑ pain in lower arms and hands
T2	Hear, including its valves and covering, coronary arteries.	❑ Functional heart conditions and certain chest conditions
T3	Lungs, bronchial tubes, pleura, chest, breast.	❑ Bronchitis ❑ pleurisy ❑ pneumonia ❑ congestion ❑ influenza
T4	Gallbladder, common duct.	❑ Gallbladder conditions ❑ jaundice ❑ shingles
T5	Liver, solar plexus, circulation (general).	❑ Liver conditions ❑ fevers ❑ blood pressure problems ❑ poor circulation ❑ arthritis
T6	Stomach.	❑ Stomach troubles including: ❑ nervous stomach ❑ indigestion ❑ heartburn ❑ dyspepsia ❑
T7	Pancreas, duodenum.	❑ Ulcers ❑ gastritis
T8	Spleen.	❑ Lowered resistance
T9	Adrenal and suprarenal glands.	❑ Allergies ❑ hives
T10	Kidneys.	❑ Kidney troubles ❑ hardening of the arteries ❑ chronic tiredness ❑ nephritis ❑ pyelitis
T11	Kidneys. ureteres.	❑ Skin conditions such as acne ❑ pimples ❑ eczema ❑ boils
T12	Small intestines, lymph circulation.	❑ Rheumatism ❑ gas pains ❑ certain types of sterility
L1	Large intestines, inguinal rings.	❑ Constipation ❑ colitis ❑ dysentery ❑ diarrhea ❑ some ruptures or hernias ❑
L2	Appendix, abdomen, upper leg.	❑ Cramps ❑ difficult breathing ❑ minor varicoses veins
L3	Sex organs, uterus, bladder, knees.	❑ Bladder troubles ❑ menstrual troubles such as painful or irregular periods ❑ miscarriages ❑ bed wetting ❑ impotency ❑ change of life symptoms ❑ many knee pains
L4	Prostate gland, muscles of the lower Back, sciatic nerve.	❑ Sciatica ❑ lumbago ❑ difficult painful or too frequent urination ❑ backaches
L5	Lower legs, ankles, feet.	❑ Poor circulation in the legs ❑ swollen ankles ❑ weak ankles and arches ❑ cold feet ❑ weakness in the legs ❑ leg cramps
SACRUM	Hip bones, buttocks.	❑ Sacroiliac conditions ❑ spinal curvatures
COCCYX	Rectum, anus.	❑ Hemorrhoids (piles) ❑ pruritus (itching) ❑ pain at end of spine on sitting

NECK REGION · MID-BACK · LOW-BACK · PELVIS

	Greatly disturbed (3-5 hours sleepless)	4
	Completely disturbed (5-7 hours sleepless)	5
My recreation activities	Cause no pain	0
	Cause some pain	1
	Cannot do all of them because of pain	2
	Can only do a few of them because of pain	3
	Can hardly do any of them because of pain	4
	Can't do any at all	5

OFFICE USE ONLY

%

YOUR TOTAL POINTS

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PATIENT TO DOCTOR CHIROPRACTIC CARE EXPECTATION ACKNOWLEDGEMENT

It is important for our office to fully understand the expectations of our patients. And, for our patients to fully know the stages of chiropractic care we offer. Please fill out the questionnaire below to help us better understand your needs.

There are essentially three stages of chiropractic care, place a check mark next to each type care you are seeking;

_____ **Yes I want; Acute care / Pain Relief: Phase I**

The goal is to relieve immediate pain and improve function of the spine. Remove the nerve interference at the spinal segments minimizing the spasms in the muscles. Spinal alignments should not be expected to stay for more then 1-2 days in this limited time of care, but towards the end of the first phase of care your pain will be drastically eliminated. * Appointments are more frequent during this phase of care.

_____ **Yes I want; Rehabilitative Care / Spinal Correction: Phase II**

The goal is to continue the healing process, help prevent any relapses, and eliminate pain as much as possible at this point. Adjustments are beginning to hold for 2-4 days at this phase. Another **very important goal** is retrain your spine proper alignment with muscle memory from consecutive spinal adjustments, and break up scar tissue.

* Appointments begin to space out.

_____ **Yes I want; Retainer Spinal Care: Phase III**

This phase of care is just like wearing a retainer after braces.

The goal is to have retrained your spine to hold proper alignment, help eliminate nervous system interference and allow your body to perform with optimized function and movement. This allows you to stay in the best health of your life.

* Appointments are commonly once a month or once every few months.

Activities of Daily Living – How does your condition interfere with life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting					Grocery Shopping				
Rising out of chair					Household chores				
Standing					Lifting objects				
Walking					Reaching overhead				
Lying down					Showering/bathing				
Bending over					Dressing				
Climbing Stairs					Rolling in bed				
Using a computer					Getting to sleep				
Getting in/out of a car					Staying asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____ Date: _____/_____/_____

BACK TO HEALTH CHIROPRACTIC PRIVACY POLICY:

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying BHC in writing except to the extent BHC has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that BHC may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by re question a notice in person.

You have the right to request BHC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. BHC is not required to agree to requested restrictions. If BHC agrees to the requested restriction, BHC will honor the request and it will be binding on the office.

I hereby consent to the use and disclosure by Back to Health Chiropractic, its workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations.

I _____(print name) do here by give Back to Health Chiropractic permission

for 1:_____2: _____3:_____
to receive patient medical records and accounting information on my behalf.

Dates effective: _____/_____/_____ to _____/_____/_____

Patient Name: _____

Patient Signature: _____ Date: _____

BHC Employee: _____ Date: _____

PIP (AUTO) INSURANCE VERIFICATION FORM

Back to Health Chiropractic ◆ 3075 West 7800 South, West Jordan UT 84088 ◆ 801 565-9500

Auto Insurance: _____ Phone #: _____Fax #: _____
Adjuster: _____ #: _____ e: _____
Address: _____ City: _____ State: _____ Zip: _____
Guarantors Name: _____ DOB: _____ ID # _____
Address: _____ Phone #: _____
Patient name: _____ DOB: _____ SS# _____
Address: _____ Phone #: _____

FOR OFFICE USE ONLY

PIP $ _____ used $ _____

CPT code	Current Charges *May change with out notice	Patient Initials	
NP 99201 to 99204	$ to $	x: _____	
RE 99213 to 99214	$ to $	x: _____	
Adj. 98940 to 98943	$ to $	x: _____	
X-rays all 7 codes	$ to $	x: _____	
PT codes all 97 codes	$ to $	x: _____	
Patient auto lien signed: Yes			
Patient Attorney: _____			

ASSIGNMENT OF BENEFITS:
I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Back to Health Chiropractic.
RELEASE OF INFORMATION:
I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.
PAYMENT AGREEMENT:
I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

My annual deductible: $_____ amount met for 2017: $_____ remainder: $_____
My approximate per visit co-pay $ _____ (X) # visits needed _____ = Total $_____

Patient Signature: _____ Date: _____

Back to Health: _____ Date: _____

AUTO ACCIDENT

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Patient Name: _____ **Date of Accident:** _____

Year, Make, and Model of the car you were in: _____

Please describe where in the vehicle you were: (ex. driver, front passenger, etc.) _____

Others in the car with you: _____

Road conditions: □ Dry □ Wet □ Icy □ Gravel Road **Visibility outside:** □ Good □ Moderate □ Poor

At Impact, was your vehicle: □ Stopped □ Moving (Speed _____ MPH) **Direction headed:** □ North □ South □ East □ West

Did the vehicle you occupied strike something during the collision? □ Yes □ No If yes, what did you hit? _____

If you struck another vehicle, was the vehicle: □ Stopped □ Moving If moving estimate speed _____ MPH

What was the estimated cost of repair to the vehicle you were in? $_____ □ Unknown

Who was at fault for the accident? □ You □ Driver of the car you were in □ Other driver □ Undetermined

Was your head facing forward at the time of the accident? □ Yes □ No If not how was it turned? _____

Were you wearing a seatbelt at the time? □ Yes □ No If so, what kind? □ Shoulder □ Lap **Did an airbag inflate?** □ Yes □ No

Did your body hit any part of the vehicle? □ Yes □ No Describe:

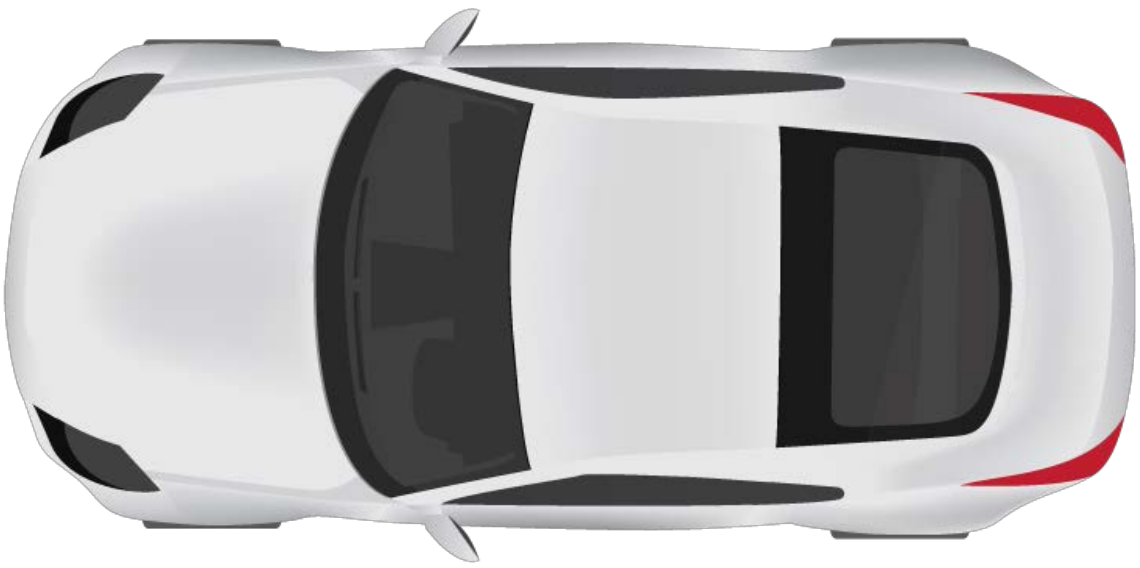
_____

Did you lose consciousness? □ Yes □ No If so, how long? _____ **Did you brace yourself for the impact?** □ Yes □ No

Have you been in previous auto accidents? □ Yes □ No Describe: Date: _____ Injuries: _____

_____

Please circle where the damage to your vehicle was:



IRREVOCABLE ASSIGNMENT & NOTICE OF DOCTOR'S LIEN

I do hereby irrevocable assign, transfer, and set over to Back to Health Chiropractic (BHC) any sums that may be due and owing for chiropractic services rendered, including interest, and to be rendered hereafter to me, or to the persons(s) named below by reason of the accident dated below. I authorize BHC to furnish my attorney and insurance company with a full report of my examinations, diagnosis, treatment, prognosis, etc., of myself and/or dependents(s) in regard to the accident dated below.

I fully understand that I am directly and fully responsible to BHC for all medical benefits, including major medical, submitted by Back to Health Chiropractic for service rendered to me and this agreement is made solely for BHC's protection. I further understand that such payment is not contingent upon any settlement, judgment or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, I agree to pay collection costs, interest (1.5% monthly), attorney fees, and court costs added as necessary to the total amount.

I hereby authorize and direct my attorney and/or insurance company/third party payer to pay to Back to Health Chiropractic such sums as may be due and owing for medical service rendered me by reason of this accident and by reason of any other bills that are due at BHC, including cost of reproducing records, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect BHC. I hereby further give to BHC a lien on any and all proceeds of any settlement, judgment or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries in connections therewith.

I agree to never rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement and enforceable upon the case as if it were executed to him/her.

I _____(Print Name) demand my attorney provide to Back to Health Chiropractic the date my demand letter is sent, the total amount of settlement request, the total amount of my medical bills at the time of the demand letter, and any further updates pertaining to the account.

Signature below implies agreement with the above terms and confirms the understanding that if my attorney does not wish to cooperate in protecting BHC's interest, BHC will not await payment but may declare the entire balance due and payable immediately.

Patient Name: _____ Date: _____

Patient Signature: _____ Accident Date: _____

ACKNOWLEDGEMENT OF ATTORNEY/INSURANCE COMPANY

The undersigned being attorney or insurance company of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect BHC. Any settlement of this claim without honoring this assignment/lien will cause the attorney or insurance company to be responsible to BHC for payment regardless of what the patient does. The prevailing party in any litigation resulting from enforcement of this lien shall be entitled to actual attorney's fees and court costs. Please sign, date, and promptly return one copy.

Print First and Last Name: _____ Date: _____

Signature of Attorney/Insurance Rep: _____

Name of Law Firm/Insurance Company: _____