BEYOND INNOVATION CHIROPRACTIC

Please Print **Date**: _____

First name: _____M.I:____

Last name:_____

Preferred name: _____

DOB:_____ Age: _____ Sex:_____

Address:_____

City: _____ State:_____

Zip Code:_____

Email: _____

Marital Status: _____ # of children: ____

Cell Phone:_____

Occupation:_____

Employer: _____

Insurance Name: _____

Subscriber Name:_____

Subscriber DOB:_____

Referred By: _____

Emergency Contact

Name:_____

Phone#:_____

Relationship: _____

Medicare Only:

Working Aged Beneficiary◯ Veteran◯

Disability ◯ Other Beneficiary◯

If patient is a minor (under 18yrs old), Please fill out this section. If not, skip:

Parent/ Guardian's Name: _____Date of Birth: _____Age: _____

Address: _____City/State: _____Zip: _____ Phone # _____ SS#_____

Occupation: _____ Employer: _____ Work Phone: _____

Chief Complaint or reason for today's visit? _____

How long have you had this condition? _____ Date of Onset? _____

Have you had this condition before? _____ If yes, when? _____

Is the condition related to: Work ( ) Auto ( ) Date of Accident: _____ Have you lost days form work? _____

What doctors have you seen for this condition? _____

What did they do? _____

When was your last visit to a Chiropractor? _____ Were you helped? _____

What Spinal Correction programs were you given? _____

Did you follow it? _____ If not,why? _____How did the post X-Rays look? _____

What surgeries have you had? _____

List drugs you now take (prescription & non-prescription): _____

Are you currently wearing: Heel lifts _____ Arch Supports _____ Back Brace_____

_____ Fractured Bones
_____ Auto Accidents
___ 0-1 years ago
___ 1-5 years ago
___ More than 5
_____ Other Accidents/Falls
_____ Back Curvature
_____ Arthritis
_____ Diabetes
_____ Swollen/Painful Joints
_____ Convulsions/Epilepsy
_____ Skin Problems
_____ Cancer
_____ Frequent Colds/Flu
_____ Depressed
_____ Irritable
_____ Anemia
_____ Tremors
_____ Allergies
_____ Sinus Problems

_____ Eating Disorders
_____ Trouble Sleeping
_____ Trouble Concentrating
_____ Learning Disability
_____ Headache
_____ Pain/Stiff Neck R L
_____Numbness/Tingling/Pain Arms/Hands/Fingers R or L
_____ Jaw Pain/TMJ R L
_____ Head/Shoulders Feel Tired
_____ Difficulty in Excessive (Standing, Walking, Bending, Riding, Twisting, Lifting, Household Duties)
_____ Shoulder Pain R L
_____ Dizziness
_____ Ringing in Ears R L
_____ Hearing Loss R L
_____ Fainting
_____ Loss of Balance
_____ Blurred Vision R L

_____ Double Vision R L
_____ Upper Back Pain/Stiffness
_____ Mid Back Pain/Stiffness
_____ Low Back Pain/Stiffness
_____ Numbness, Tingling or Pain in buttocks, thighs, legs, feet, toes
_____ Pain with cough, sneeze
_____ Hip Pain R L
_____ Foot Trouble R L
_____ Chest Pain
_____ Asthma
_____ Lung Problems
_____ Difficulty Breathing
_____ Heart Problem
_____ Stroke
_____ High/Low Blood Pressure
_____ Received Covid Vaccine
If yes, #_____
_____ Vascular Disease Assc W/ Covid Vaccine

_____ Varicose Veins
_____ Liver Trouble
_____ Gall Bladder Trouble
_____ Digestive Problems
_____ Heartburn
_____ Ulcers
_____ Diarrhea/Constipation
_____ Colon Trouble
_____ Hemorrhoids
_____ Prostate Problems
_____ Impotence
_____ Kidney Trouble
_____ Menstrual Problem/PMS
_____ Menopausal Problems
_____ Pregnant (now)
_____ Bed Wetting
_____ Ear Infection
_____ AIDS/HIV

Please mark X for present conditions, O for past conditions

BEYOND INNOVATION CHIROPRACTIC

Symptomatology: *(continued from page one)*

Problem Area #1

The pain is located _____

The pain started _____

The pain is made better by _____

and worse by _____

How would you describe the pain:_____

[ ] There is [ ] There is not referred or radiating pain into_____

[ ] There is [ ] There is not paresthesia(tingling/numbness) into:_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Additional Area #2

The pain is located_____

The pain started_____

The pain is made better by_____

and worse by_____

How would you describe the pain:_____

[ ] There is [ ] There is not referred or radiating pain into_____

[ ] There is [ ] There is not paresthesia(tingling/numbness) into:_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

Additional Area #3

The pain is located_____

The pain started_____

The pain is made better by_____

and worse by _____

How would you describe the pain:_____

[ ] There is [ ] There is not referred or radiating pain into _____

[ ] There is [ ] There is not paresthesia(tingling/numbness) into:_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.)_____

On a scale of 1- 10 rate your pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain**

BEYOND INNOVATION CHIROPRACTIC

THIS DOCUMENT COSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental, and social well being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression to the body's innate wisdom. Our only method is the specific adjustment of vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

POLICIES

1. All first visit charges are payable when services are rendered since it is impossible to determine what insurance covers without a diagnosis of severity.
2. The fee paid for X-rays is for the analysis of those X-rays only. The film itself is the property of this office. Original X-rays can not be released; however, copies can be made at minimal charge.
3. I have read Beyond Innovation Chiropractic's Notice of Patient Privacy Practices.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Beyond Innovation Chiropractic (BIC) will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to BIC will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

In case of emergency, notify _____ Phone # _____

I, _____, have read and fully understand the above statements. All questions
(Print Name)
regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis. _____ _____
(Signature) **(Date)**

COMPLETE IF THE PATIENT IS A MINOR CHILD: Child's Name: _____

I, _____ being the parent or legal guardian of the above-mentioned child have read
(Print Parent/Legal Guardian's Name)
and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Parent/Legal Guardian's Signature) **(Date)**