



<b>Please Print Date:</b> _____ First name: _____ M.I.: _____ Last name: _____ Preferred name: _____ DOB: _____ Age: _____ Sex: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Email: _____	Referred By: _____ Marital Status: _____ # of children: _____ Home Phone: _____ Cell Phone: _____ Occupation: _____ Employer: _____ Insurance Name: _____ Subscriber Name: _____ Subscriber DOB: _____	<b style="color: red;">Emergency Contact</b> Name: _____ Phone#: _____ Relationship: _____  <b>Medicare Only:</b> Working Aged Beneficiary <input type="radio"/> Veteran <input type="radio"/> Disability <input type="radio"/> Other Beneficiary <input type="radio"/>
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**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 \_\_\_\_\_

<input type="checkbox"/> Fractured Bones	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Double Vision R L	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Auto Accidents	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Upper Back Pain/Stiffness	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> 0-1 years ago	<input type="checkbox"/> Trouble Concentrating	<input type="checkbox"/> Mid Back Pain/Stiffness	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> 1-5 years ago	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Low Back Pain/Stiffness	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> More than 5	<input type="checkbox"/> Headache	<input type="checkbox"/> Numbness, Tingling or Pain in	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Other Accidents/Falls	<input type="checkbox"/> Pain/Stiff Neck R L	buttocks, thighs, legs, feet, toes	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Numbness/Tingling/Pain	<input type="checkbox"/> Pain with cough, sneeze	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Arthritis	Arms/Hands/Fingers R or L	<input type="checkbox"/> Hip Pain R L	<input type="checkbox"/> Colon Trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Jaw Pain/TMJ R L	<input type="checkbox"/> Foot Trouble R L	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> Head/Shoulders Feel Tired	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Difficulty in Excessive	<input type="checkbox"/> Asthma	<input type="checkbox"/> Impotence
<input type="checkbox"/> Skin Problems	(Standing, Walking, Bending, Riding,	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Cancer	Twisting, Lifting, Household Duties)	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Menstrual Problem/PMS
<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Shoulder Pain R L	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Menopausal Problems
<input type="checkbox"/> Depressed	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Stroke	<input type="checkbox"/> Pregnant (now)
<input type="checkbox"/> Irritable	<input type="checkbox"/> Ringing in Ears R L	<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hearing Loss R L	<input type="checkbox"/> Received Covid Vaccine	<input type="checkbox"/> Ear Infection
<input type="checkbox"/> Tremors	<input type="checkbox"/> Fainting	If yes, # _____	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Allergies	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vascular Disease Assc W/	
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Blurred Vision R L	Covid Vaccine	

**Please mark X for present conditions, O for past conditions**

**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**

## THIS DOCUMENT COSTITUATES 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)