BEYOND INNOVATION CHIROPRACTIC

Please Print Date: _____	DOB: _____ Age: _____ Sex:___	Employer: _____
First name: _____M.I:____	SS #: _____	Insurance Name: _____
Last name:_____	Referred By: _____	Subscriber Name:_____
Preferred name: _____	Marital Status: _____ # of children: ____	Subscriber DOB:_____
Address:_____	Home Phone:_____	Emergency Contact:_____
City: _____State:_____	Cell Phone:_____	Phone#:_____
Zip Code:_____	Work Phone:_____	Relationship: _____
Email: _____	Occupation:_____	

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

Please mark X for present conditions, O for past conditions

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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 Living Well 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

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 and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) **(Date)**