BACK IN ACTION
CHIROPRACTIC

TODAY'S DATE: _____

PATIENT ID:_____

PATIENT INFORMATION

Name: (Last)_____ (First)_____ (Middle Initial)_____

Address:_____

City:_____ State:_____ Zip:_____

Home Number:_____ Work Number:_____ Cell number:_____

E-mail Address: _____ May we leave messages at the above numbers ☐ Yes ☐ No

Birth Date:_____ Sex: ☐ Male ☐ Female Preferred Greeting Name:_____

Relationship to Policyholder: ☐ Same ☐ Spouse ☐ Child ☐ Other _____

Patient Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Student

Occupation:_____ Employer's Name:_____ Phone Number:_____

Referred to Office by: ☐ Doctor ☐ Friend ☐ Facebook ☐ Instagram ☐ Family ☐ Insurance List ☐ Internet Search ☐ Other _____

INSURANCE INFORMATION

Primary Insurance:_____ Phone:_____

Address:_____

Policy Claim Number:_____ Group #:_____

Check box if the following information has been completed above: ☐ Information Completed

Policyholder's Name (if different than above): (Last)_____ (First)_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Birth Date:_____ Sex: ☐ Male ☐ Female

Secondary Insurance:_____ Phone:_____

Address:_____

Policy Claim Number:_____ Group #:_____

Check box if the following information has been completed above: ☐ Information Completed

Policyholder's Name: (Last)_____ (First)_____ (Initial)_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Birth Date:_____ Sex: ☐ Male ☐ Female

BACK IN ACTION
CHIROPRACTIC & MASSAGE

Name:_____

Date:_____

MASSAGE QUESTIONNAIRE

What are your current complaints/symptoms?_____

_____

_____

Is the complaint **currently**: ☐ constant (76-100%) ☐ frequent (51-75%) ☐ occasional (26-50%) ☐ intermittent (0-25%)

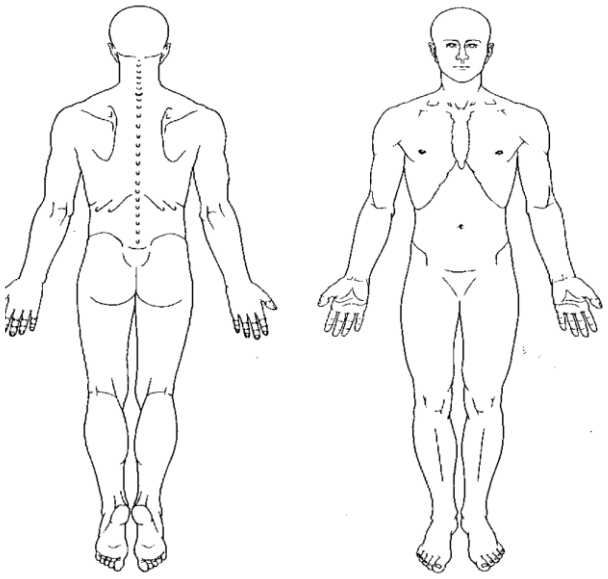
Mark any condition that applies to you **either now or in the past**. (mark all that apply)

☐ Arthritis ☐ Bruise Easily ☐ Decreased Sensation/Numbness ☐ Fibromayalgia
☐ Headaches/Migraines ☐ Low Back Pain ☐ Lymphedima ☐ Muscle Sprain/Strain
☐ Osteoporosis ☐ Pregnant ☐ Skin Infections ☐ Varicose Veins

PAIN RATING

Please indicate on the drawing the location of your current symptoms. Use the symbols shown below to represent the type(s) of symptoms:

D=Dull Ache
B=Burning
N=Numbness
S=Stabbing/Sharp
T=Tingling
O=Stiffness/Tightness
X=Spasm



Please describe & rate the severity of your current complaint (10 = worst pain, 0 = no pain) **during the past week**:

At its **worst**:

0 1 2 3 4 5 6 7 8 9 10

At its **best**:

0 1 2 3 4 5 6 7 8 9 10

Currently:

0 1 2 3 4 5 6 7 8 9 10

What level of massage would you prefer? (mark all that apply)

☐ Light ☐ Medium ☐ Deep ☐ Very Deep

Would you prefer music or no music?

☐ Music ☐ No Music

Would you prefer quiet or conversation?

☐ Quiet, please! ☐ Feel free to talk

Do you have any smell sensitivity?

☐ No ☐ Yes If yes, what? _____.

PATIENT NAME: _____

Welcome to Back in Action Chiropractic and for choosing us to help you with all of your health care needs. Our mission is to provide the highest quality of chiropractic care to the members of our community and to help educate you about your health and the steps that you can take to ensure good health for a lifetime. Before receiving care in our office it is important to be familiar with our policies:

CONSENT TO TREAT: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic those working at the clinic or office who or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below. I have the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to exam and treatment however I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. By signing below, I consent to the treatment plan, I intend this consent to form to cover the entire course of treatment for my condition and for any past or future condition(s) for which I have been under care or will seek. . **_____Initial**

INSURANCE ASSIGNMENT: Back in Action Chiropractic is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim or reimbursement of charges incurred by me as a result of professional services rendered by Back in Action Chiropractic. I do hereby assign irrevocable direct payment to the health care professionals, and any contractees, the health care benefits due for the total charges or payments equal to the reimbursement rate as may be appropriate, for any services not covered by this assignment. I hereby instruct and direct any obligated company or individual to pay check made out and mailed to Back in Action Chiropractor. **_____Initial**

FINANCIAL AGREEMENT: Payment of co-pays and non-insurance covered services is expected at the time of service. I agree, whether I am signing as agent or as a patient, that in consideration of the services to be rendered to the patient, I individually obligate myself to pay the account of the health care professional in accordance with the regular rates and terms of the health care professionals. I understand that the health care profession shall have the right at any time to refuse to admit me or provide health care treatment for me. The health care professionals, as a courtesy to the patient, agree to extend credit by awaiting payment from the insurance company, provided any deductible and co-payment are paid on a per-visit-basis for no longer than 60 days from the date of service at which time the account is due and payable. If the patient should discontinue treatment against the recommendations of the health care professional, then the entire balance is due and payable immediately. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney fees and collection expenses. There will be a $15.00 charge for returned checks. I further agree that the above mentioned health care provider be given power of attorney to endorse/sign my name on any checks for the payment of my health care professional's bill. Should an over-payment be made, a refund check will be sent to the authorized party that is due the over-payment. The health care professional reserves the right to have billing services performed by a contracted billing service and the health care professional reserves the right to charge the patient an amount equal to the billing services rate for any over-payment**.** **_____Initial**

APPOINTMENTS: A missed appointment is a loss to everyone. Please give 24 hours notice if you are unable to keep your appointment; **otherwise we reserve the right to charge $30 for the time reserved.** This charge is **your responsibility**, as insurance companies do not pay for missed appointments**.** **_____Initial**

The undersigned certifies that he/she has read and understood the foregoing is entitled to a copy of the same upon request, and is the patient, or is duly authorized as the patient's general agent to execute the above and accept its terms.

_____	_____	_____
Patient's or Responsible Party's signature	**Date of Signing**	**Relationship to Patient**