

Today's date: \_\_\_\_\_

**PATIENT INFORMATION** **INSURANCE INFORMATION**

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F  Married  Single  Other  
(MM/DD/YYYY)

Address: \_\_\_\_\_  
City State Zip

Primary Phone: \_\_\_\_\_  Mobile

Secondary: \_\_\_\_\_  Mobile

eMail: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

Secondary Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

**DETAILED INFORMATION**

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

EMERGENCY CONTACT:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

**ACCIDENT INFORMATION**

If this was an accident, when did it occur? \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

What type of accident was it?  Auto  Work  Other

Insurance Company: \_\_\_\_\_

Claim #: \_\_\_\_\_ Phone: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE ASSIGNMENT AND RELEASE**

I, the undersigned, hereby instruct and direct my insurance company to pay by check, made out and mailed directly to the above named office, the professional and medical expense benefits allowable and otherwise payable to me under my current policy agreement as payment toward the services rendered. I understand that I am financially responsible for all charges for services provided me (or my dependent). A photocopy of this assignment shall be considered as effective and valid as the original.

Responsible party name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YY)

Quite possibly one of the most asked questions is how often we will need to treat a person before they get better. To be honest, everyone is different: your age, length and severity of illness, and desire to get better all factor into your results. Your practitioner will use the information provided in this packet combined with details from your interview and examination to come up with a treatment plan designed *specifically* for you!

While the level of care will always be the same, how far you want to take it will determine how much your life will improve. There are some, oddly enough, who just want to stop the pain temporarily and walk away from treatment the moment their symptoms ease only to return to start the process all over again a few months later. At Balance we will craft a plan to not just relieve your symptoms, but also to correct the underlying conditions which created the situation in the first place, resulting in a more robust, happy, and pain-free life. How far you go is up to you!

**HOW OFTEN WILL I NEED TREATMENT?** **FREQUENCY OF CARE**



**Acute Care:** frequent treatments targeted at resolving the key symptoms and provide relief.

**Continuing care:** reduced frequency with the intention of correcting imbalance and maintaining reduced symptoms.

**Wellness care:** infrequent treatments designed to maintain Balance, prevent relapse, and protect future health.

**INFORMED CONSENT**

I hereby request and consent to the performance of acupuncture, chiropractic and /or massage treatments and other procedures within the scope of practice of my provider on me (or on the person named below, for whom I am legally responsible) by the practitioner I see now or other practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for my practitioner, including those working at the clinic or office listed above, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, chiropractic, moxibustion, cupping, electrical stimulation, ultrasound, Tui-na (oriental manual therapy), massage, herbal medicine, exercise and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that chiropractic therapy is a generally safe method of treatment, but that it may have some side effects including non-painful cavitations or “popping” and soreness in the area following treatment. The cavitation or “popping” commonly occurs during an adjustment and is caused by the joint fluid converting from a liquid to a gas and is a normal side effect of the treatment. Unusual risks of chiropractic treatments include soft tissue injury, physical therapy burns, rib fracture and very rare disc herniation and stroke. I understand that while this document describes the major risks of chiropractic treatment, other side effects and risks may occur.

I have been informed that massage therapy is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, and the possible aggravation of symptoms after treatment.

The herbs and nutritional supplements that have been recommended are traditionally considered safe when prescribed by competently trained practitioners. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of treatment, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment

**CLINIC POLICIES AND PROCEDURES**

**Payment for services:** payment is to be made at the time services are rendered unless insurance arrangements have been verified in advance. Payment may be made in the form of cash, credit card, or personal check.

**Insurance billing:** we will gladly submit claims to your health carrier on your behalf. You are responsible for your co-pay, co-insurance, and any amounts declined or applied to your deductible.

**Herbs and supplements:** products in addition to treatment can range from \$4-\$60 and are not included in any discount program. These products must be paid for at the time of receipt. Open product is non-refundable.

**Appointment changes:** your appointment time is reserved specifically for you and is timed to give you the most time with your practitioner. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice, we reserve the right to charge a \$25 fee *per practitioner*. Health insurance will not cover a missed appointment.

**Closure due to inclement weather:** in the case of inclement weather please call the clinic prior to your appointment. Our status will be noted on our voicemail.

**PATIENT SIGNATURE**

I have read the above consent, policies and procedures and have completed this form with the understanding that omissions or inaccuracies may adversely impact the ability of my practitioners to make an educated and thorough diagnosis, and therefore my treatment.

\_\_\_\_\_  
 Printed name of patient (or guardian)

\_\_\_\_\_  
 Signature of same

\_\_\_\_\_  
 Date

Today's date: \_\_\_\_\_

**BASIC HEALTH INFORMATION/NEW INJURY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F

Reason for visit: \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

What caused them? \_\_\_\_\_

Since onset, have your symptoms been getting  Better  Worse  No change

Other providers seen for this: \_\_\_\_\_

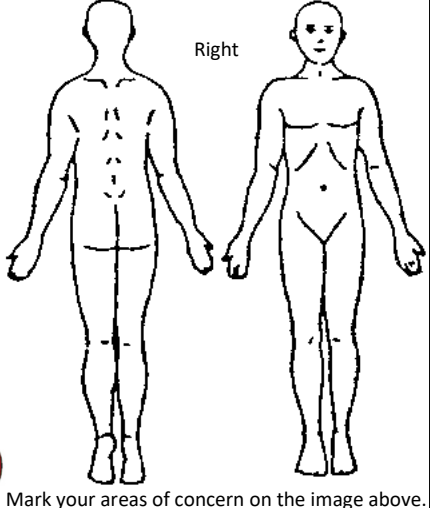
Does it interfere with your  Sleep  Work  Daily Routine  Recreation

What makes your symptoms better? \_\_\_\_\_

What makes you symptoms worse? \_\_\_\_\_

Please circle the number that corresponds to the severity of your symptoms.

0 1 2 3 4 5 6 7 8 9 10



**SURGICAL HISTORY** **ALLERGIES OR REACTIONS TO MEDICATION**

List with year: \_\_\_\_\_

**CURRENT MEDICATION/SUPPLEMENTS**

Please list all medications or supplements with dose: \_\_\_\_\_

**FAMILY MEDICAL HISTORY** PLEASE CHECK  FOR YOU AND  FOR FAMILY HISTORY.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Obesity            |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Hyper/Hypo Thyroid | <input type="checkbox"/> Osteoporosis/penia |
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Measles            | <input type="checkbox"/> Parasites          |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Heart Attack _____  | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke _____       |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis       |

**PERSONAL HEALTH INFORMATION**

<b>HEALTH HABITS</b>	Alcohol: _____glasses / day week month	<b>WORK ACTIVITY</b>	<input type="checkbox"/> Sitting	<b>FEMALE HEALTH</b>	Date of last menses: _____	<input type="checkbox"/> Menopause
	Caffeine: _____glasses / day week month		<input type="checkbox"/> Standing		Age of first period: _____	<input type="checkbox"/> PMS
	Tobacco: _____packs / day week month		<input type="checkbox"/> Computer		Menses: <input type="checkbox"/> Spotting <input type="checkbox"/> Light <input type="checkbox"/> Heavy	<input type="checkbox"/> Absent
	Stress: None Moderate Daily Heavy		<input type="checkbox"/> Light Labor		<input type="checkbox"/> Irregular <input type="checkbox"/> Painful <input type="checkbox"/> Clots	<input type="checkbox"/> Y <input type="checkbox"/> N
	Exercise: None Moderate Daily Heavy		<input type="checkbox"/> Heavy Labor		Are you currently pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Hazards	Are you currently breast feeding?	<input type="checkbox"/> Y <input type="checkbox"/> N			
	<input type="checkbox"/> Repetitive	# of pregnancies: _____	# of live births: _____			

**PERSONAL SIGNS AND SYMPTOMS**PLEASE CHECK  FOR ALL THAT APPLY.**General**

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Bleed easily    | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Poor sleep         | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Bruise easily   | <input type="checkbox"/> Fever            | <input type="checkbox"/> Peculiar tastes  | <input type="checkbox"/> Short temper       | <input type="checkbox"/> Vivid dreams   |
| <input type="checkbox"/> Chills          | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Poor appetite    | <input type="checkbox"/> Sweat easily       | <input type="checkbox"/> Weight gain    |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Muscle cramps    | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Weight loss    |

**Head, Ears, Eyes, Nose, and Throat (HEENT)**

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Blurry vision     | <input type="checkbox"/> Ear aches         | <input type="checkbox"/> Excess saliva  | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Sinus pain         |
| <input type="checkbox"/> Concussion        | <input type="checkbox"/> Headache/migraine | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Nose bleeds      | <input type="checkbox"/> Spots in eyes      |
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Thyroid issues    | <input type="checkbox"/> Itchy eyes     | <input type="checkbox"/> Red eyes         | <input type="checkbox"/> Sore throat        |
| <input type="checkbox"/> Dry throat/mouth  | <input type="checkbox"/> Eye pain/strain   | <input type="checkbox"/> Mouth sores    | <input type="checkbox"/> Ringing ears     | <input type="checkbox"/> Teeth/gum problems |

**Respiratory**

- |                                    |   |  |  |                                      |
|------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cough          | <input type="checkbox"/> Frequent cold/flu | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Tight chest |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Phlegm            | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing    |

**Cardiovascular**

- |                                      |   |  |  |                                      |
|--------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Edema/swelling | <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Phlebitis   |
| <input type="checkbox"/> Chest pain  | <input type="checkbox"/> Fainting       | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Tachycardia |

**Gastrointestinal**

- |  |   |  |   |   |
|--|---|--|---|---|
| <input type="checkbox"/> Abdominal pain/<br>bloating | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Floating stools | <input type="checkbox"/> Indigestion                | <input type="checkbox"/> Nausea         |
| <input type="checkbox"/> Acid reflux                 | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Gas/belching    | <input type="checkbox"/> Intestinal pain/<br>cramps | <input type="checkbox"/> Odorous stools |
| <input type="checkbox"/> Bad breath                  | <input type="checkbox"/> Dark stools    | <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Mucous in stools           | <input type="checkbox"/> Rectal pain    |
|  | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Hiccups         |   | <input type="checkbox"/> Vomiting       |

**Musculoskeletal**

- |   |                                       |  |   |  |
|---|---------------------------------------|--|---|--|
| <input type="checkbox"/> Low back pain      | <input type="checkbox"/> Redness/heat | <input type="checkbox"/> Limited range | <input type="checkbox"/> Rib pain       | <input type="checkbox"/> Moving pain       |
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Swelling     | <input type="checkbox"/> Limited use   | <input type="checkbox"/> Dull/achy pain | <input type="checkbox"/> Stabbing pain     |
| <input type="checkbox"/> Upper back pain    | <input type="checkbox"/> Joint pain   | <input type="checkbox"/> Muscle pain   | <input type="checkbox"/> Fixed pain     | <input type="checkbox"/> Throbbing/burning |

**Skin and Hair**

- |                                   |  |   |                                       |                                      |
|-----------------------------------|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acne     | <input type="checkbox"/> Dry/brittle nails | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Rash/hives  |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Dry skin          | <input type="checkbox"/> Fungal infection | <input type="checkbox"/> Psoriasis    | <input type="checkbox"/> Ulcerations |

**Neuropsychological**

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Considered or attempted<br>suicide | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Poor memory        | <input type="checkbox"/> Sudden weakness |
| <input type="checkbox"/> Anxiety        |   | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Seeing a therapist | <input type="checkbox"/> Tics            |
| <input type="checkbox"/> Confusion      | <input type="checkbox"/> Depression                         | <input type="checkbox"/> Numbness        | <input type="checkbox"/> Seizures           | <input type="checkbox"/> Tingling        |

**Genitourinary**

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Dribbling urine    | <input type="checkbox"/> Incomplete urine | <input type="checkbox"/> Nocturnal emission  | <input type="checkbox"/> Premature ejaculate |
| <input type="checkbox"/> Blood in urine   | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Urgent urination    |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Impotence          | <input type="checkbox"/> Kidney stones    | <input type="checkbox"/> Painful erection    | <input type="checkbox"/> Wake to urinate     |

**PATIENT SIGNATURE**

I have completed this document to the best of my ability and understand that any omissions may impact the ability of my providers to make an appropriate diagnosis and/or treatment plan.

\_\_\_\_\_  
Printed name of patient (or guardian)

\_\_\_\_\_  
Signature of same

\_\_\_\_\_  
Date

Eric Strand, LAC ♦ Daniel DesJardins, DC  
Christina Lambert, LAC ♦ Tyler Burke, DC ♦ Jessica Ulmer, LMT ♦ Erik Wold, LMT ♦ Brooke Braga, LMT

Provider Reviewed:  
on

**YOUR PRIVACY**

**IS OUR PRIORITY**

### HIPAA PRIVACY NOTIFICATION

I consent to the use or disclosure of my identifiable health information by practitioners operating at *Balance Health and Injury Clinic, PC* (hereon noted as *Balance*) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Balance* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Practitioners operating at *Balance* are not required to agree to the restrictions that I may request. However, if practitioners operating at *Balance* agree to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that practitioners operating at *Balance* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review *Balance's* Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is also provided at the front desk and on the organizations' web sites at [www.balhic.com](http://www.balhic.com). This Notice of Privacy Practices also describes my rights and the duties of my practitioners with respect to my identifiable health information.

The practitioners operating at *Balance* reserve the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

### PATIENT SIGNATURE

I have read the above notification and understand my rights to privacy as a patient.

\_\_\_\_\_  
Printed name of patient (or guardian)

\_\_\_\_\_  
Signature of same

\_\_\_\_\_  
Date

Please welcome me with my name

I do not feel comfortable having you welcome me by name

Eric Strand, LAC ♦ Daniel DesJardins, DC

Tyler Burke, DC ♦ Christina Lambert, LAC ♦ Jessica Ulmer, LMT ♦ Erik Wold, LMT ♦ Brooke Braga, LMT