Balanced Care Chiropractic

2500 W. Higgins Rd., Ste. 965, Hoffman Estates, IL 60169

Office Use

F/C: ☐ INS ☐ MC ☐ MD ☐ IO ☐ WC ☐ AA ☐ PI ☐ SP BCC# _____

Included: ☐ Insurance Card Copy ☐ Employer Claim Form ☐ Referral/Script

ABOUT YOU

First Name: _____ **Last Name**: _____ **Date**: ___/___/_____

Preferred Name: _____ Date of Birth: ____/____/_____ Age: _____ Sex: M F

Street Address: _____

City: _____ State: _____ ZIP: _____

E-Mail: _____ Cell #: _____ Other #: _____

Emergency Contact: _____ Relation: _____ #: _____

Height: _____ft. _____in. Weight: _____lbs. Occupation: _____

How did you hear about us: _____

Status: Minor Single Married Divorced Separated Widow **Spouse Name**: _____

Do you have children? Yes No How many? _____ Names: _____

INSURANCE INFO

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: _____ Birthdate:_____

(Person Ultimately Responsible for account) Name: _____Phone: _____

Please inform front desk of any 2nd Insurance source

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection with expenses as the result of doctor services.

Patient Signature: _____ Date: _____

REASON FOR VISIT

What health condition(s) bring you into our office? _____

_____

Have you received care for this problem before? Yes No

- If yes, please explain: _____

When did the condition(s) first began? _____

How did the problem start? Suddenly Gradually Post-injury

How often do you experience your symptoms?

1.Constantly (75%-100%) 2.Frequently (51%-75%) 3.Occasionally (26%-50%) 4.Intermittently (0%-25%)

Is this condition: Getting worse Improving Intermittent Constant Unsure

Does the pain radiate?, to where: _____

What makes the problem better? _____

What makes the problem worse? _____

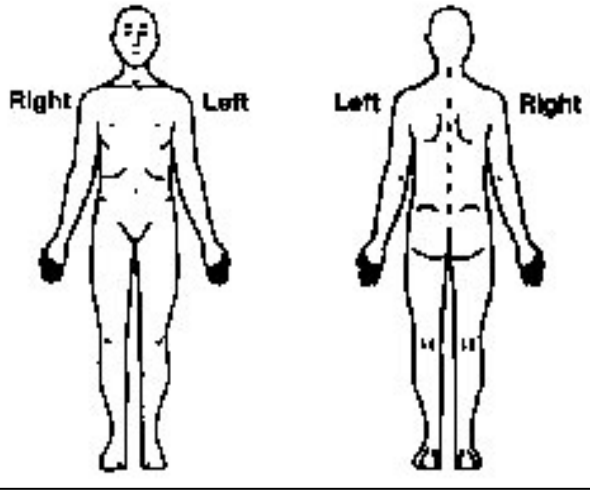
Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

In general, how is your overall health right now? Excellent Very good Good Fair Poor

Type of pain: ☐Sharp ☐Stabbing ☐Numb ☐Dull ☐Achy ☐Burning ☐Tingling ☐Stiff

Please indicate where you are experiencing the following symptoms:



Please circle your level of pain below:
(0=no pain; 10=worst pain imaginable)

Last 24 hours
0 1 2 3 4 5 6 7 8 9 10

Past week
0 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

List current Medications (prescription & over the counter): _____

Please list anything you may be allergic to: _____

Circle "Y" if you have ever had any of the following diseases or conditions?

Y Heat Attack/ Stroke	**Y** Heart Surg/Pacemaker	**Y** Heart Murmur
Y Congenital Heart Defect	**Y** Mitral Valve Prolapse	**Y** Artificial Valves
Y Alcohol/ Drug Abuse	**Y** Venereal Disease	**Y** Hepatitis
Y HIV+ / AIDS	**Y** Shingles	**Y** Cancer
Y Frequent Neck Pain	**Y** Emphysema/Glaucoma	**Y** Anemia
Y High/Low Blood Pressure	**Y** Psychiatric Problems	**Y** Rheumatic Fever
Y Severe/Frequent Headaches	**Y** Kidney Problems	**Y** Ulcers/ Colitis
Y Fainting/Seizures/Epilepsy	**Y** Sinus Problems	**Y** Asthma
Y Diabetes / Tuberculosis	**Y** Difficulty Breathing	**Y** Chemotherapy
Y Lower Back Problems	**Y** Artificial Bones/Joints	**Y** Arthritis

If you circled "Y" to any of the above, please explain:

_____

Are you receiving care from any other health professionals? Yes No **Who**? _____

Have you ever visited a chiropractor before? Yes No How long ago? _____

Have you ever had any significant falls, surgeries or other injuries as an adult? Yes No

- If yes, please explain: _____

Notable childhood injuries? Yes No Explain:_____

Any auto accidents? Yes No Explain: _____

Exercise Frequency? None 1-2x/week 3-5x/week Daily **Type:**_____

Do you smoke: Current Smoker Former Smoker Never Smoked

How many hours/day do you spend sitting at a desk or on a computer, tablet or phone? _____

List any problems with flexibility. (ex. Putting on shoes/socks, etc.) _____

Please note any significant family medical history: _____

For Women: **Are you taking birth control**? Yes No **Nursing**? Yes No

Are you pregnant? Yes No / **Due date**? _____

OFFICE POLICIES

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Your health insurance is a contract between you and your insurance carrier. I understand I am totally responsible for all services rendered at **Balanced Care Chiropractic, LLC**, even if my insurance company denies payment for any reason whatsoever.
- **All cancellations & reschedules require 12 hour notice or a $30 fee will be charged**. Insurance will not cover.
- **"No Shows" will be subject to a $30 fee before rescheduling**. Insurance will not cover.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ___/___/_____