

Welcome to Back 2 Health Chiropractic

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
AGE:	
SOCIAL SECURITY #:	GENDER:
MARITAL STATUS:	# OF CHILDREN:
EMPLOYER:	
Address:	Work Phone:
PAYMENT METHOD: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> CARE CREDIT	

ABOUT YOUR SPOUSE

SPOUSE NAME:
Spouse Employer:
Spouse Birth Date:

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU WEAR:
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> INSULIN
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> PAIN KILLERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME:
APPROXIMATE DATE OF LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

Describe the Reason for this Visit

DESCRIBE THE REASON FOR THIS VISIT:
SYMPTOMS DEVELOPED FROM: <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> JOB RELATED INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER Please Explain:
WHEN DID THIS CONCERN BEGIN?
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES Please Explain:
HAS THIS CONCERN OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO Please Explain:
HAVE YOU SEEN OTHER DOCTORS FOR THIS CONCERN? <input type="checkbox"/> YES <input type="checkbox"/> NO
DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

SUPPLEMENTS YOU TAKE

<input type="checkbox"/> ESSENTIAL FATTY ACIDS	<input type="checkbox"/> PROBIOTIC
<input type="checkbox"/> MULTIVITAMIN WHICH: _____	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> CALCIUM / MAGNESIUM	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> VITAMIN C	<input type="checkbox"/> OTHER _____

Insurance Information

Name of Insurance Subscriber _____
 Relationship to patient _____
 Subscriber's Date of Birth _____
 Insurance Company _____
 ID # _____ Group# _____
 Is patient covered by additional insurance? ___ Yes ___ No
 Subscriber's Name _____ DOB _____
 Relationship to patient _____
 Insurance Company _____
 ID# _____ Group# _____

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have Ins. Coverage with _____ and assign directly to Dr. Mistretta all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information needed to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

Many problems and health challenges can start as 'nerve interference' blocking the vital power that operates and heals our body. **Please CIRCLE below any concerns you are experiencing now as well as in the past.** Feel free to list any other concerns or health challenges you may be having under 'other'.

YOUR CONCERNS

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions



C1 Headaches
C2 Migraines
C3 Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

T2 Middle Back Pain
T3 Congestion
T4 Difficulty Breathing
T5 Bronchitis
T6 Pneumonia
T7 Gallbladder Conditions
T8 Stomach Problems
T9 Ulcers
T10 Gastritis
Kidney Problems

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Problems
Menstrual Problems
Low Back Pain
Pain or Numbness in legs
Reproductive Problems

OTHER:

"The doors we open and close each day decide the lives we live."

GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- Relief care:** Symptomatic relief of pain or discomfort.
- Corrective care:** Correcting and relieving the cause of the problem as well as the symptom.
- Comprehensive care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
- I want the Doctor to select the type of care for my condition.*

HEALTH CONDITIONS...

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	IF YES, WHEN IS YOUR DUE DATE?
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	<i>DO YOU:</i> EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	

SURGERIES: (PLEASE LIST ALL SURGERIES YOU HAVE HAD)

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. 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 then known, is in my best interest.

By signing below I agree to the above and allow the doctor, affiliated with Back 2 Health Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____ Date: _____

AUTHORIZATION FOR CARE

I hereby authorize Dr. Mistretta to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Dr. Mistretta will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to Dr. Mistretta for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGN IF READ ABOVE _____ DATE _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: