



BALANCE IN MOTION
the wellness studio

Welcome to
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Congratulations! You have taken the first step toward better health. Balance in Motion partners with our patients to help them live a healthier and more enjoyable life.

The following forms will help us understand your current health needs so that we can determine if you are a good candidate for our care. Please take the time to respond honestly and thoroughly. Our policies are also provided so that you are fully informed of our business practices.

Based on your history information and our initial assessment and tests, our team will design a treatment plan for you that integrate various techniques and tools to best suit your unique needs.

We look forward to serving you.

Thank you,

Your ***Balance in Motion*** Team of Professionals

Please fill out the following information thoroughly so that our team has all the information we need to best help you. Feel free to ask any questions.

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ - _____ - _____ Today's date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Gender: *M or F* Marital Status: *S M D W* Height: _____ Weight: _____ Age: _____ SS#: _____

Occupation: _____ Pregnant: *Yes No* If yes, how far along: _____

Spouse's or Partner's Name: _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Number of Children: _____ Are there any concerns you have about their health? _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____

Would you like us to check for insurance coverage? *Yes No* **If yes, please give us your insurance card to make a copy.**

Email: _____@_____ Would you like to receive our monthly newsletters? *Yes No*

How did you hear about us? _____

PURPOSE OF THIS VISIT

What brought you in today? _____

When did it start? _____ Did your symptoms come on ___ *Gradually* or ___ *Suddenly*

What were you doing when you first noticed it? _____

Are your symptoms due to a motor vehicle accident? *Yes No* Are your symptoms due to an injury at work? *Yes No*
If yes, when? _____ If yes, when? _____

Have you experienced this condition before? *Yes No* When: _____

Does this condition interfere with: ___ *Work* ___ *Sleep* ___ *Family* ___ *Hobbies* ___ *Daily Routine* ___ *Mood* ___ *Social*

Explain _____

Have you had any prior treatment for this condition? *Yes No* Explain _____

How did your body respond? _____

Please check any injuries/traumas you have had.

___ Sports injuries	___ Recreational injuries	___ Work injuries	___ Accidents
Date _____	Date _____	Date _____	Date _____
Details _____	Details _____	Details _____	Details _____
_____	_____	_____	_____

SYMPTOM DESCRIPTION

If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain Location: _____	Pain Location: _____	Pain Location: _____
RIGHT NOW: _____ / 10	RIGHT NOW: _____ / 10	RIGHT NOW: _____ / 10
At its WORST: _____ / 10	At its WORST: _____ / 10	At its WORST: _____ / 10
At its BEST: _____ / 10	At its BEST: _____ / 10	At its BEST: _____ / 10
At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10

What makes your pain DIMINISH? (Check all that apply):

<input type="checkbox"/> Nothing	<input type="checkbox"/> Ice	<input type="checkbox"/> Heat	<input type="checkbox"/> Massage/Rubbing	<input type="checkbox"/> Rest
<input type="checkbox"/> Exercise/Activity	<input type="checkbox"/> Sitting	<input type="checkbox"/> Laying	<input type="checkbox"/> Standing	<input type="checkbox"/> Bracing/taping
<input type="checkbox"/> Stretching	<input type="checkbox"/> "Popping" the joints	<input type="checkbox"/> Other: _____		

What makes your pain WORSE? (Check all that apply):

<input type="checkbox"/> Coughing	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Bearing Down	<input type="checkbox"/> Lifting	<input type="checkbox"/> Movement of the low back
<input type="checkbox"/> Bending	<input type="checkbox"/> Pushing	<input type="checkbox"/> Pulling	<input type="checkbox"/> Driving	<input type="checkbox"/> Movement of the head
<input type="checkbox"/> Sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Running	<input type="checkbox"/> Standing	<input type="checkbox"/> Laying down
<input type="checkbox"/> Other: _____				

Would you describe your pain as:

<input type="checkbox"/> Constant	<input type="checkbox"/> Frequent	<input type="checkbox"/> Occasional	<input type="checkbox"/> Seldom	<input type="checkbox"/> Other _____
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Pain Quality: How would you describe your pain/discomfort (Check all that apply):

<input type="checkbox"/> Dull	<input type="checkbox"/> Achy	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Stiff	<input type="checkbox"/> Burning	
<input type="checkbox"/> Sharp	<input type="checkbox"/> Sharp with movement	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Shooting	<input type="checkbox"/> Intense	
<input type="checkbox"/> Constricting					<input type="checkbox"/> Other: _____

Radiating: Does your pain seem to radiate from the primary area: *Yes No* If Yes, where to? _____

Numbness/Tingling (pins and needles): Do you experience or have you ever experienced numbness and/or tingling anywhere? *Yes No*

If Yes, when do you notice it and where on your body: _____

Is your pain/discomfort WORSE:

<input type="checkbox"/> In the morning	<input type="checkbox"/> In the evening
<input type="checkbox"/> In the afternoon	<input type="checkbox"/> While sleeping
<input type="checkbox"/> It does not seem to be affected by the time of day	

Is your pain/discomfort BETTER:

<input type="checkbox"/> In the morning	<input type="checkbox"/> In the evening
<input type="checkbox"/> In the afternoon	<input type="checkbox"/> While sleeping
<input type="checkbox"/> It does not seem to be affected by the time of day	

MEDICAL/TREATMENT HISTORY

Have you previously consulted a chiropractor or physical therapist? *Yes No* Approximate date of last visit: _____

How was your experience?

Are you currently taking: Prescription medication? *Yes No* Over the counter medication? *Yes No*

Vitamins or supplements? *Yes No*

Previous surgeries (all types):

Approximate date:

1. _____

2. _____

3. _____

SUBSTANCE SURVEY FORM

Please list any **PRESCRIPTION MEDICATION** you are currently taking or have taken in the last 2 years

Medication

Daily Dosage

Diagnosis or Symptom

Dates of Use

Please list any **OVER THE COUNTER MEDICATIONS** you are currently taking or have taken in the last 2 years

Medication

Daily Dosage

Diagnosis or Symptom

Dates of Use

Please list any **VITAMINS, SUPPLEMENTS, OR HERBS** you are currently taking or have taken in the last 2 years

Medication

Daily Dosage

Diagnosis or Symptom

Dates of Use

CIRCLE THE FOLLOWING ITEMS WHICH APPLY TO YOU AND INDICATE THE AMOUNT USED:

Coffee Y / N _____

Candy Y / N _____

Alcohol Y / N _____

Tea Y / N _____

Ice Cream Y / N _____

Cigarettes Y / N _____

Soft drinks Y / N _____

Artificial sweetener Y / N _____

Other tobacco products Y / N _____

Antacids Y / N _____

Laxatives Y / N _____

How many desserts do you have in an average week? _____

Are you on any special diet? Yes No If so, describe _____

YOUR HEALTH & LIFESTYLE

How much would you say the following contribute to/cause your symptoms? (0 = not at all, and 10 = a great deal)

- | | | | |
|---|------------------------|-------------------------|------------------------|
| • Bad posture | 0 1 2 3 4 5 6 7 8 9 10 | • Stress | 0 1 2 3 4 5 6 7 8 9 10 |
| • Previous Injuries | 0 1 2 3 4 5 6 7 8 9 10 | • Lifestyle habits | 0 1 2 3 4 5 6 7 8 9 10 |
| • Sedentary lifestyle
(a lot of time driving, sitting, TV) | 0 1 2 3 4 5 6 7 8 9 10 | • Being out of
shape | 0 1 2 3 4 5 6 7 8 9 10 |
| • Office/home ergonomics | 0 1 2 3 4 5 6 7 8 9 10 | • Lack of time | 0 1 2 3 4 5 6 7 8 9 10 |
| • Family history or genetics | 0 1 2 3 4 5 6 7 8 9 10 | • Lack of energy | 0 1 2 3 4 5 6 7 8 9 10 |

ADDITIONAL COMMENTS

AUTHORIZATION

I certify that I have read and understand the information on the previous pages and have answered the questions to the best of my knowledge. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such chiropractic care to third party payers and or health practitioners. I authorize and request that my insurance company pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

Print Name _____ Signature _____ Date _____
(signature of parent, if the patient is a minor)

RELEASE OF HEALTH CARE INFORMATION (HIPAA)

The doctors and members of the ***Balance in Motion*** team may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health-related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may inspect or copy at any time the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information. This is your right under Federal Law.

You can restrict the individuals or organizations to which your health care information is released, or you may revoke your authorization to us at any time. Your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before receiving your verification request in writing. In addition, if you were required to give your authorization as a condition of obtaining insurance benefits, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

By signing below, I authorize ***Balance in Motion*** to use or disclose my health information in the manner described above.

Print Name _____ Signature _____ Date _____
(signature of parent, if the patient is a minor)

OPEN ROOM TREATMENT AND THERAPY

Balance in Motion provides treatment and therapy in an open environment, with other patients in the same room. Occasionally comments about your symptoms and/or conditions may be discussed during your office visits and others may overhear the discussion. Exams and consultations however are completed in a private room. Please let your doctor/practitioner know if you would like to speak privately about a question you have or any concern(s).

By initialing here _____, I am giving my consent to treatment in the open environment.

INFORMED CONSENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked." You may also feel movement of the joint. A minority of patients may notice stiffness or soreness after the first few days of treatment. Please know this is not unhealthy and is to be expected. Various ancillary procedures, such as hot or cold packs, mechanical traction, and k-laser may also be used.

Possible risks: As with any form of health care, complications are possible with chiropractic care. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risk(s) of complications due to chiropractic treatment are statistically proven to be rare, about as often as complications are seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one-in-one million to one-in-twenty million, and are further reduced by screening procedures that we automatically employ. The probability of adverse reaction due to ancillary procedures is also rare.

Other treatment options which could be considered may include the following:

- **K-Laser** – K-laser treatment is extremely safe and painless. Patients may experience a gentle warming effect during treatments and/or a temporary increase in soreness after treatment. K-laser is not to be used over the eyes due to the sensitivity of the retina, therefore all patients will be provided protective safety glasses during treatment.
- **Massage Therapy** – Patients may experience temporary pain or discomfort, bruising, swelling, etc. The risks of complications due to massage therapy are rare. Please inform the massage therapist if you are pregnant, have any known physical conditions, medical conditions and are on any medications.
- **Acupuncture** – Patients may experience bruising, fainting, dizziness, muscle spasms, bleeding, infection, etc. These risks are considered very rare. To reduce the possibility of infection, our acupuncturist uses only pre-sterilized, one-time-use needles made of surgical stainless steel. Please inform the acupuncturist if you are pregnant, have any known physical conditions, medical conditions and are on any medications.

Balance in Motion has trained personnel to assist the doctor with portions of your care, including consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. When your doctor/therapist is unavailable, another doctor/therapist will treat you on that day.

By initialing here _____, I am giving my consent to be treated by another doctor/therapist if my doctor/therapist is unavailable.

By signing below, I acknowledge that I have read the above information and have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

Print Name _____ Signature _____ Date _____
(signature of parent, if the patient is a minor)

CANCELLATION POLICY

In order to serve all of our patients and provide the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

We realize circumstances occur and you may need to change an appointment. We ask that you notify us at least **4 business hours** in advance of the appointment time. If at least a four hour notice is not provided, no-shows and cancellations will be charged \$20.00 for 30 minute appointments (Regular Chiropractic, Massage, K-Laser, etc) or \$40 for 60 minute appointments (New Patient Exams, Massage, Acupuncture, Nutrition, etc).

The more notice you provide, the better we can serve all patients. If you reach our voicemail, please leave a message and we will call you back to reschedule. Thank you in advance for your cooperation!

By signing below, I acknowledge that I understand and agree to the terms of the Cancellation Policy.

Print Name _____ Signature _____ Date _____
(signature of parent, if the patient is a minor)

FINANCIAL RESPONSIBILITY

Co-insurance: The amount shared by you and your insurer for covered services after you have met your deductible. This is expressed as a ratio, typically 80/20 (80% paid by your insurer and 20% paid by you.)

Co-pay: Unlike co-insurance, which is based on a percentage of the cost, a co-pay is a flat fee paid for a specific service, such as \$20 for an office visit.

Deductible: The amount you must pay for services rendered before your health insurance will make any benefit payments. This is an annual amount.

As a courtesy to you, **Balance in Motion** will call your insurance company to verify your benefits. We assume no liability for errors made by your insurance company in this quote. We will review the coverage with you. It is then your responsibility to pay any balance remaining after your insurance carrier has paid its portion of the bill.

If you have a **deductible** that has yet to be met, we will collect payment from you directly. This payment goes toward your deductible, and you will need to pay for your service out-of-pocket until your deductible is met. Once your deductible has been met, we will collect your **co-pay** or **co-insurance** at the time of services.

If Balance in Motion is not an "in network" provider with your insurance carrier, there is a chance that the covered benefit checks will be sent from your insurance carrier directly to you, the patient, rather than to us, the provider. The amount of these checks is due to us in addition to any co-pay or co-insurance. Please ensure that this amount is promptly paid to us for services rendered.

If any of your checks are returned unpaid, we will assign a fee of \$25. If you refuse to pay your bill and we are forced to initiate collections proceedings, we will add a service fee of 20% to your total bill.

By signing below, I acknowledge that I understand and agree to the terms of the Financial Responsibility.

Print Name _____ Signature _____ Date _____
(signature of parent, if the patient is a minor)