4702 James Savage Rd, Midland MI 48642
223 N Kaiser St, Pinconning MI 48650

Patient Name:	Date:
Email:	

Chiropractic Case History

Have you ever received chiropractic care? Y N If yes, when?
Primary reasons for seeking chiropractic care:
Other reasons:
Location of chief complaint:
When did this complaint begin?
Initial cause of this complaint:
Are you presently under a doctor's care for this complaint? Y N Dr's. Name:
Circle the type of complaint: *Dull/Aching/Sharp/Shooting/Burning/Throbbing/Deep/Other*
Does this complaint radiate/shoot to other areas of your body? Y N Where?
Do you have numbness/tingling in your body? Y N If yes, where?
Grade intensity/severity *(0 = No Pain, 10 = Worst Pain Possible)*: 0 1 2 3 4 5 6 7 8 9 10
How frequent is complain present?
How long does it last?
Does this complaint/pain interfere with: work, home life activities or sleep?
Does anything aggravate the complaint/pain?
Does anything make the complaint/pain better?

Previous Interventions:

Treatments, medications, surgery or care you've sought for your complaint/pain:

Health History:

Previous illnesses you've had in your life:
Previous injury or trauma:
Please state any bone(s) you have broken:
Allergies:
Medications:
Smoking *(Circle one)*: *Never smoker* *Former smoker* *Current casual smoker* *Current daily smoker*
Surgeries and dates:
Pregnancies & date of delivery:
On a scale of 1-10, how committed are you to resolving this complaint/pain?
Are there any other health concerns you would like to address?

Patient Name:	Date:

Patient Information

Name:	Today's Date:	
Referred by:	Date of Birth:	
Address:		
City:	State:	Zip:
Gender: M F	Phone:	
Emergency contact name:	Emergency contact number:	
Responsible party *(if patient is a minor)*:		

Insurance Information *(Please present insurance card and ID for photocopy)*

Primary Insurance company name:	
Enrollee ID #	Group #
Policy holder:	Policy holder phone:
Policy holder DOB:	Policy holder employer:

Secondary Insurance company name:	
Enrollee ID #	Group #
Policy holder:	Policy holder phone:
Policy holder DOB:	Policy holder employer:

Insurance

Initial________ In order to submit a claim for payment to us for services covered under your policy, I must have authorization to release medical information to your insurance company and to my billing company for paper and electronic billing. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Balanced Living Chiropractic and its billing company to file for benefits on my behalf for Chiropractic services received. Insurance payments shall be made directly to Balanced Living Chiropractic. If I have Medicare insurance, I authorize Balanced Living Chiropractic to release to the Social Security and Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by Balanced Living Chiropractic by written request. I consent to Balanced Living Chiropractic to provide professional services to me.

Consent for Purposes of Treatment, Payment, and Healthcare Operations

Initial________ I acknowledge that Balanced Living Chiropractic, PLLC's "Notice of Privacy Practices" has been provided to me. I understand I have the right to review Balanced Living Chiropractic PLLC's Notice of Privacy Practices prior to signing this document. Balanced Living Chiropractic, PLLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Balanced Living Chiropractic, PLLC. The Notice of Privacy Practices for Balanced Living Chiropractic, PLLC is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Balanced Living Chiropractic PLLC's duties with respect to my protected health information. Balanced Living Chiropractic, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient *(or Personal Representative)*:	Date:
Name of Patient (or Personal Representative):	
Description of Personal Representative Authority if applicable:	