BALANCED CHIROPRACTIC

Patient History

Name _____ **Age** _____ **Date of Birth** ____/____/_____ **Sex** ____
(Please indicate preferred name in parentheses if applicable)

Address _____ **City** _____ **State** _____ **Zip** _____

Email _____ **Phone** (_____)_____-_____ **Occupation** _____

Referred by _____ **How did you hear about us?** _____

Past Chiropractic care (Y/N) _____ **When?** _____ **Did it help?** _____

Past Surgeries _____

Serious Injuries _____

Health Conditions _____

Chief Complaints Today

(Please circle problems, intensity of pain and indicate how long each issue has been ongoing)

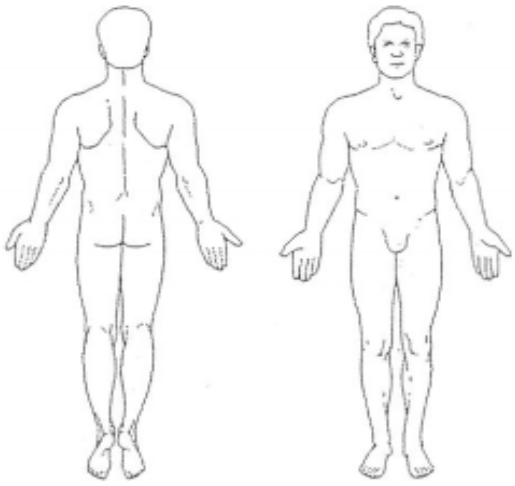
1 = Least Intense **10 = Most Intense**

1. _____ **Onset?** _____
1 2 3 4 5 6 7 8 9 10

2. _____ **Onset?** _____
1 2 3 4 5 6 7 8 9 10

3. _____ **Onset?** _____
1 2 3 4 5 6 7 8 9 10

Circle Pain



Anything else you want Doctor to know? _____

_____

HIPAA Privacy Practices Acknowledgment

This notice describes how your protected health information (PHI) may be used and disclosed, and how you can access this information. Please review it carefully.

Our Responsibilities

- Maintain the privacy of your protected health information.
- Provide you with a description of our privacy practices.
- Abide by the terms of this notice.

Your Rights

- You may request restrictions on certain uses and disclosures.
- You may request confidential communications.
- You may inspect and obtain a copy of your health record.
- You may request corrections to your health record.

Use and Disclosure of PHI

We may use and disclose your health information for purposes of treatment, payment, and healthcare operations. Examples include sharing information with another healthcare provider for treatment, submitting information to your insurance company for payment, or using information internally to improve the quality of care.

I acknowledge that I have been provided the Notice of Privacy Practices for Balanced Chiropractic. This notice describes how my health information may be used and disclosed and how I may access this information. I understand that I may request a copy at any time.

Patient Name: _____ Date: _____

Signature: _____ Parent/Guardian (if minor): _____

Informed Consent for Chiropractic Treatment

Chiropractic care is generally safe and effective but may involve certain risks. These may include temporary soreness, stiffness, or discomfort. Rare complications may include aggravation of symptoms, rib injury, stroke-like symptoms, or other unforeseen complications.

I understand that results are not guaranteed. I authorize Balanced Chiropractic and Dr. Tyler M. Graham, DC, to perform chiropractic evaluations and treatments as deemed necessary.

I understand that I may discontinue treatment at any time.

Patient Name: _____ Date: _____

Signature: _____ Parent/Guardian (if minor): _____