BACKBONE
WELLNESS INSTITUTE
CHIROPRACTIC | REHABILITATION | THERAPY
513.891.2111 www.backbonewellness.com

WELCOME TO OUR CLINIC

Backbone Wellness Institute specializes in assisting our local community to achieve their highest level of health and wellness through an intergraded chiropractic approach. Backbone utilizes a multidisciplinary team of doctors and therapists to treat the underlining cause of your symptom and/or problem. We specialize in the removal of ***Spinal Subluxations, Postural Corrective Programs and Non-narcotic Pain Management.*** Our approach is very unique and advanced from other medical, chiropractic, or physical therapy rehabilitative programs. This allows our patients to achieve far superior results compared to most other healthcare systems.

Please fill out the following information thoroughly. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____

Patient Signature:

_____

Today's Date:

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Work Activity: □ Sit □ Stand □ Light Labor □ Heavy Labor □ Other: _____

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

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Primary Care Physician: _____ Phone: _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Name of Your Health Insurance Co: _____

Policy #: _____ Group #: _____

Address _____ Phone # _____

Insured's Name if different than yours _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Birth date _____/_____/_____

Employer _____

SECONDARY INSURANCE INFORMATION

Name of Your Health Insurance Co._____

Policy # _____ Group # _____

Address _____ Phone # _____

Insured's Name if different than yours _____ Insured's SS# _____/_____/_____

Relationship to Insured _____ Birth date _____/_____/_____

Employer _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any money received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services □YES □ NO

Patients Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

I hereby authorize Backbone Wellness Institute to administer care as deemed necessary to my child, a minor under the age of 18 years old.

PATIENT CASE HISTORY

Reason for Appointment: _____

Describe Major Complaint: _____

Began When? ___/_____/_____ Describe how thins began: _____

Grade Intensity / Severity of Complaint: □ None □ Mild □ Moderate □ Severe □ Very Severe

Quality of the Complaint / Pain: □ Stiff □ Dull □ Achy □ Sharp □ Shooting □ Shooting □ Burning □ Numb

Other: _____ How Frequent is the complaint present: □ Off & On □ Constant

Does this complaint radiate / shoot to any areas of the body? □ No □ Yes (Describe) _____

Head □ Base of Skull □ Forehead □ Side-Temple □ R □ L □ Both

Glute / Leg □ Hip □ Thigh / Knee □ Calf □ Foot / Toes □ R □ L □ Both

Shoulder / Arm □ Across Shoulder □ Elbow □ Hand / Fingers □ R □ L Both

Other Area: _____

Symptoms Worse: □ Morning □ Afternoon □ Night □ Same All Day □ Varies: _____

Tried Relieving Symptoms with: □ Heat □ Ice □ Rest □ Stretching □ OTC □ Modified Activity □ Other: _____

Does Anything Make the Complaint Worse? □ Sit □ Stand □ Walk □ Lying □ Sleep □ Overuse □ Other: _____

Which Daily activities are be affected by this condition? (describe) _____

For this CURRENT condition, have you:

Received any other treatment? □ None □ MD □ DC □ PT □ Massage □ ER □ Other: _____

Who? _____ When did you see this health care provider ? _____

Had any Medications? □ OTC □ Prescriptions

Had Any Diagnostic Testing? □ X-Rays □ MRI □ CT □ Other: _____ When and Where? _____

How did you respond to care? _____

Describe any Secondary Complaints: _____

Have you been treated for any other health condition in the last year? □ No □ Yes (Explain) _____

HEALTH AND LIFESTYLE

Do you exercise? □ Yes □ No How often? 1X 2X 3X 4X 5X per week Other: _____

What activities? □ Running □ Jogging □ Weight Training □ Cycling □ Yoga □ Pilates □ Swimming □ Other: _____

Do you smoke? □ Yes □ No How much? _____

Do you drink alcohol? □ Yes □ No How much / week? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Please list any medications you are currently taking □ Pain Killers □Muscle Relaxers □ Insulin □Cholesterol Meds

□ Blood Pressure Meds □ Birth Control □Other: _____

Do you experience any of the following conditions?

CERVICAL SPINE (NECK):

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent colds/Flue
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):

- ❑ Heart Palpitations
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions not mentioned: _____

What is your goal in this office? _____

Do you have a pace maker □ YES □ NO Have you ever had any Hip or Knee replacements □ YES □ NO

Have you been tested positive for an Infectious Disease □ YES □ NO, if yes please state: _____

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor and/or therapist to work with my body and spine through the use of one of the following: medical treatments, chiropractic adjustments and rehabilitative exercises for the purpose of structural restoration of normal biomechanical and neurological function of the body.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctors and/or therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctors and/or physical therapist for all services rendered.

_____	_____	_____	_____
Patient's Printed Name	Date	Patient's Signature	Date

_____	_____	_____
Minors Name	Guardian/Spouse's Signature of Authorizing for minor	Date

RADIOGRAPH CONSENT FORM

I _____ do hereby give my consent to allow Backbone Wellness Institute and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

Female Only: I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____

IN CASE OF EMERGENCY

Name _____ Relationship _____

Cell Phone _____ Work Phone _____

Home Phone _____

HIPPA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES **BACKBONE WELLNESS INSTITUTE** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Backbone Wellness Institute to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Backbone Wellness Institute to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with one of the Doctors or Physical Therapist in private, the Doctor or Therapist will provide a private room for these conversations. By signing the following you are giving Backbone Wellness Institute permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT &
NOTICE OF PRIVACY PRACTICES

I _____ on this date _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office.

Whew! Congratulations... You're Done!!!

At this time, we ask that you please hand your application into the front desk.