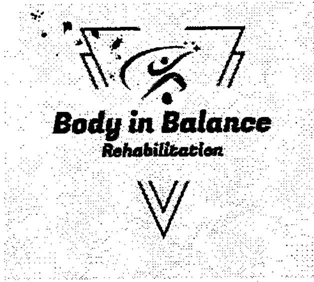


Patient Registration

Name:____

Date of Birth: ________________ Gender: M or F

Address:____

Home#________________ Cell#________________

Email:____

Emergency Contact : Name ______________________________

Emergency phone #________________Relationship________________

Referring MD:______________________ Phone#________________

You are responsible for your copay, coinsurance, and deductibles (if any)

Your copay/coinsurance has been verified as:________________per visit

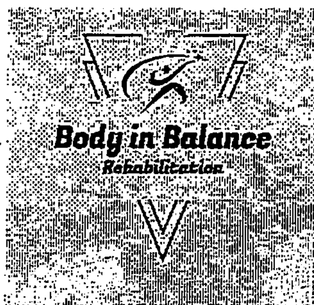
Consent to treat and authorization to release information

I authorize Body in balance to furnish medical care and treatment considered necessary and proper in diagnosing or treating my/his/her physical condition.

And I further authorize Body In Balance to release to appropriate agencies any information acquired in the course of my/his/her examination and treatment necessary to secure payment for services provided.

Signature____________________________Date________________

***Cancellation/No Show policy*: cancellation notice is required, if unable to attend a scheduled visit. A valid reason will be accepted if you call. Otherwise, there will be a $40 charge for all unexcused missed appointments.**



Privacy Notice

(HIPAA)

NAME________________________

Keeping your health information private is one of our most important responsibilities. We are committed to following the State and Federal laws regarding the use of your personal health information. The Health Insurance Portability and Accountability Act states:

1. We will protect and keep your health information from others who do not need to know it.
2. You may have a copy of this notice.
3. You may revoke your permission at any time.

Information that may be released without written permission include:

For public health reasons, Court ordered by subpoena, Law enforcement requests, National Security purposes and to whom ever you designate allowable to access your records.

I authorize Body In Balance to disclose my health information regarding my treatment to:

Name:____Relationship:__________________

Please sign to acknowledge that you have read this policy:

Name____

Date____

NAME ____________________ DATE __________

Health History

Main **Condition** being Treated for: ______________________________

Precautions: (Did the doctor tell you to **avoid** any specific movements or activities)?

____

Do you wear a **Brace/ Orthotic:** ______________________________

I have a: MRI / CT scan / Xray / EMG/NCV / ER visit / Neurologist / Orthopedic/ Podiatrist

Surgeries: ______________________________

Are you **pregnant**: yes / no Do you **smoke**: yes / no Take a **blood thinner**: yes/ no

Current **Exercise** program: ______________________________

I **have** a: walker / cane / shower chair / wheelchair / hospital bed / shower bars

I **live** in (apartment/house/condo) with (1/ 2/ 3) floors and _____# steps to enter

I do my own: driving / cooking / cleaning / food shopping / financial management

Allergies: latex / adhesive / other: ______________________________

____

Circle any of the following that are part of your **medical history** (Current & Past):

Cardiac:
- Shortness of breath / chest pain
- Coronary Heart disease / angina
- Pacemaker / defibrillator
- High blood pressure / low blood pressure
- Heart attack
- Stroke or Mini-stroke (TIA)
- Blood clot / Embolism / anyeurism
- Anemia

- Diabetes
- Wounds
-
- Vertigo
- GERD/ Reflux
- Hernia

Height: _________

Weight: _________

Dominant Hand: _______

Falls: yes / no

Orthopedic:
- Fracture
- Osteoporosis / osteopenia
- Osteoarthritis / swollen joints / Gout
- Rheumatoid Arthritis
- Pins or metal implants
- Joint replacements
- Herniated Disk
- Plantar Fascitis

- Bursitis
- Rotator Cuff Tear

- Sciatica
- Tendonitis
- TMJ synd
- Carpal Tunnel Synd.

Mental / Emotional:
- Depression
- Anxiety / worry
- Social isolation
- Substance abuse
- Memory problems/ forgetfullness
- Emotional Regulation Problems
- Difficulty sleeping
- Difficulty concentrating

- **Are you seeing a:**
- ** Chiropractor **
- Psychologist
- Psychiatrist
- Support Group

Neurological:
- seizures / Epilepsy
- Vision difficulty / double vision
- Hearing difficulty / Hearing aide
- numbness/ neuropathy
- Tingling
- Muscle Weakness / muscle tightness
- Fatigue / low endurance
- Dizziness upon standing

- DBS
- Other Implated Device

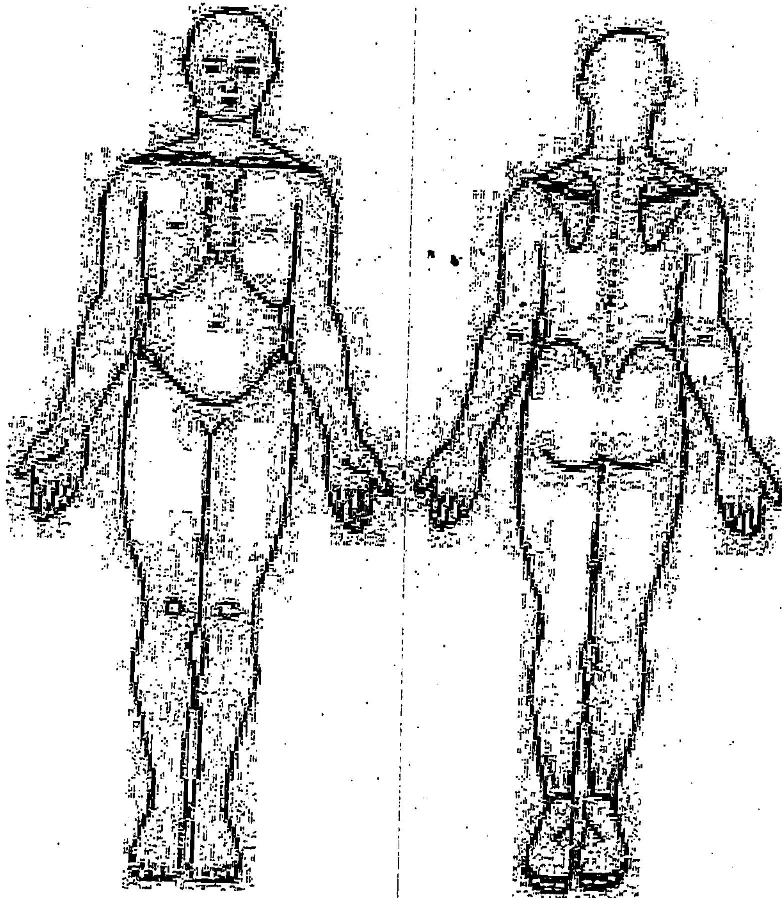
Other:
- swelling / lymphedema
- Vericose veins
- Blood Clot, DVT
- Kidney Failure / dialysis / transplant
- Bowel or bladder problems
- Cancer: ______________________
- Chemotherapy / Radiation
- Headaches
- Difficulty swallowing
- Infectious disease (MRSA/ Hepatitis...)

- Asthma
- COPD
- Pneumonia
- Bronchitis

- Shingles

Did your **Medicare Benefits** start due to : Age / Disability / End Stage Renal Disease

NAME____________________ DATE__________



Using the graph to the left, please indicate your symptoms using the key below:

Numbness ========

Pins/needles 00000000

Burning Pain xxxxxxxxxx

Stabbing Pain ///////////

Are you having pain now? Yes____ No____

If yes, please rate on a scale of 0-10 where 0 is no pain and 10 is worst pain ever: ________

Have you had any therapy anywhere besides Body In Balance in this year? Yes____ No_____

If yes, how many visits ______ Where______________________________

Are you having any services at your home, for any reason, billed through your current insurance? Yes____ No____. If yes, for what and with which company?______________________________

Are you currently having any chiropractic care? Yes____ No____ (you cannot do therapy the same day as chiropractic)

Is your visit related to a motor vehicle accident, slip & fall or workman's comp accident? Yes____No____ If yes, what is it related to:______________________________

When did the accident occur:____________________

Current Medications List

NAME ____________ DATE ____________

Prescription Medications:

Name of Medication	Strength dosage	Frequency	Oral or Injection	Notes

Adopted from: Aging in Stride – Plan Ahead, Stay Connected, Keep Moving · www.AgingInStride.org