



BAC TO HEALTH WELLNESS

ABOUT THE PATIENT

Name _____
 Address _____
 City/State/Zip _____
 SS# _____
 Gender M F # of Children _____
 Birth Date _____
 Marital Status _____ Partner _____
 Employer _____

Is this appointment for

Family
Wellness

 Or

Yourself
A Condition

 ?

Home Phone _____ Work _____
 Cell Phone _____
 E-Mail _____

Whom may we thank for referring you? _____

Emergency Contact _____
 Phone _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment is related to:
 Wellness Sports Auto Fall
 Chronic Discomfort Home Other

When did this condition begin?
 Has this condition Gotten worse Same
 Intermittent

Does this condition interfere with
 Work Sleep Routine Other

Explain _____

Has this condition occurred before? Yes No

Have you seen other doctors for this condition?
 Yes No

Dr.'s Name _____
 Type of treatment _____
 Results _____

EXPERIENCE WITH CHIROPRACTIC

Have you been adjusted by a Chiropractor before? Y N
 Reason for those visits? _____
 Doctor's Name _____
 Approximate Date of Last Visit _____

Awareness of Wellness Principles

Were you aware that

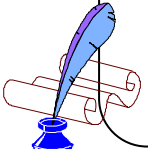
- ...Doctor's of Chiropractic work with the nervous system? Y N
- ...the nervous system controls all bodily functions and systems? Y N
- ...Chiropractic is the largest natural healing profession in the world? Y N
- ...if Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Y N



ABOUT MY INSURANCE

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I further authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to "BAC To Health" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly. Otherwise a superbill will be provided. I fully understand when the insurance company verifies my benefits, **it is not a guarantee or authorization to pay** on claims submitted. I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit. If my insurance company sends payment for services rendered to me, I agree to submit this payment to BAC To Health within seven (7) business days.

X _____ / ____ / ____
Patient/Guarantor - signature Date



SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

I am here with no symptoms. Please check my spine & nervous system for conditions I may not know about yet.

Finally, the years of continuing damage showed up as acute or chronic symptoms:

Present Complaint (be brief): _____

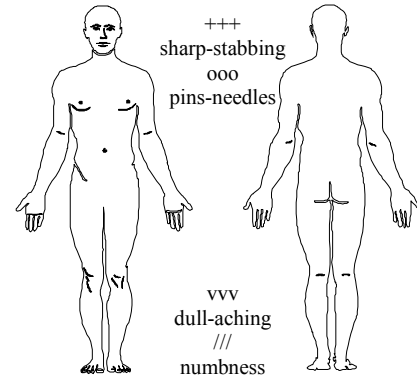
What activities aggravate your condition? _____

What activities lesson your condition/pain? _____

Any home remedies tried? _____

Have you had any surgeries? Please list: _____

Please list any other health conditions that concern you, even if you don't think that they are Chiropractic related: _____



Other symptoms

- Headaches
- Neck Pain
- Sleeping Problems
- Back Pain
- Nervousness
- Tension / Stress
- Irritability
- Chest Pains
- Dizziness / Loss of Balance
- Face Flushed / Cold Sweats
- Neck Stiff

- Pins & Needles in Legs
- Pins & Needles in Arms
- Numbness in Fingers
- Numbness in Toes / Feet
- Shortness of Breath
- Fatigue
- Depression
- Light Bothers Eyes
- Loss of Memory
- Ears Ringing
- Fever

- Fainting
- Loss of Smell / Taste
- Menstrual Pain
- Diarrhea
- Feet Cold
- Hands Cold
- Stomach Upset
- Constipation
- Buzzing in Ears
- Shoulder / Elbow Pain L or R
- Hip / Knee / Ankle Pain L or R

How Toxic are you?

- I have gotten vaccines
- I drive in my car every day
- I eat fast-food at least once a month
- I have taken OTC drugs

- I shower/bathe in tap water
- I use cosmetics
- I use artificial sweeteners
- I have taken prescription drugs

- I heat food in plastic containers
- I use standard cleaning products at home
- I drink regular or diet sodas
- I do not drink 8 glasses of water every day

Is there a family history of :

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

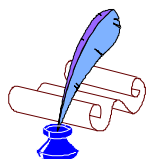
CHIROPRACTIC PROVIDES THREE TYPES OF CARE

- Initial Intensive** Corrects the most recent layer of Spinal and Neurological damage. This care only reduces or eliminates the symptoms
- Reconstructive** Corrects the years of damage that occurred when there were few symptoms. Stabilization occurs in this phase.
- Wellness** Chiropractic is a genuine approach to Maintain a Healthy Lifestyle.

All of these will be explained at your personal Report of Findings. Then you'll be able to begin a course of care that fits your health goals and needs. Some of the healthiest people in the world choose the DREAM lifestyle.

Free newsletter signup. Please check any topic that interest you:

- Doctor Announcements
- Wellness Topics
- Diet & Nutrition
- Exercise & Fitness
- Women's Health
- Children's Health
- Stress Management



Patient Name _____

Age _____ Female/Male

Patient/Guarantor's Signature _____

Date _____

Functional Assessment



Please rate how your current condition effects each category by circling a number:

	No Problems			Moderate Restrictions				Cannot function			
Home Duties <small>Yard work, dishes, etc.</small>	0	1	2	3	4	5	6	7	8	9	10
Recreation <small>Hobbies, sports, leisure.</small>	0	1	2	3	4	5	6	7	8	9	10
Social Activity <small>Functions, dining out.</small>	0	1	2	3	4	5	6	7	8	9	10
Occupation <small>Paid or non paid.</small>	0	1	2	3	4	5	6	7	8	9	10
Self Care <small>Personal care, ADL's</small>	0	1	2	3	4	5	6	7	8	9	10
Life Support <small>Eating, sleeping, breathing.</small>	0	1	2	3	4	5	6	7	8	9	10

My Score = /60

Pharmaceutical Case History

Example: Name: *Topamax*
 Dose: *20 mg*
 Frequency: *1x/day for 3 months*
 Reason for prescription: *Chronic migraines*
 Dr.'s Info (Name, City State): *Dr. Pill Popper, Beverly Hills, CA*

A. One-Year History of Prescription Medications:

Name: Dose: Frequency: Reason for prescription: Dr.'s Info:	Name: Dose: Frequency: Reason for prescription: Dr.'s Info:
Other (Please use another sheet if necessary):	

B. One Year History of Non-Prescription Medication (OTC):

Name: Dose: Frequency: Reason for taking:	Name: Dose: Frequency: Reason for taking:
Other (Please use another sheet if necessary):	

C. Vitamins and Supplements (multi, calcium, herbs, etc.):

1. 2. 3. 4. 5.

Please be advised: Stroke is a common side effect of many common prescription and OTC medications, even when properly taken. It is in your best interest to see your MD frequently to have your medications re-evaluated and/or adjusted to reduce your risk.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal and we are committed to protecting it. We create a record of the services you receive at our clinic. We need this to provide you with quality care and to comply with certain laws. This notice tells you about the ways we may use and share your information and your rights and certain duties regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

This section describes different ways that we use and disclose medical information. We have listed all of the ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your written authorization. Any written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify: a family member, your representative or other person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, if you are not able to give permission, we will share only the information that is directly necessary for your care, according to our professional judgment. We will also use professional judgment to make decisions in your best interest about allowing someone to pick up medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: We may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when law authorizes us to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with law relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, license or disciplinary action, or other authorized activities.

Law Enforcement: We may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of your medical information. You may request copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form by any office personnel. You may also request access by sending a letter to our office via mail or facsimile.
2. Receive a list of all the times we or our business associates shared your medical information for purposes not listed above.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing to our office.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others of the change and to include the changes in any future sharing of the information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

X _____ Date: _____

Patient Signature