

**Balanced Wellness Chiropractic Physicians**  
6516 N. Olie Avenue, Suite D Oklahoma City, OK 73116  
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**INTRODUCTION PATIENT CASE HISTORY**

Today's Date: \_\_\_\_\_

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**PATIENT INFORMATION**

Name: (Last, First MI) \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Mobile Carrier: \_\_\_\_\_ Work: \_\_\_\_\_  
Email: \_\_\_\_\_ Gender: M / F Marital Status: Married / Other / Single  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Student Status: Full Student / Part Student / Non-Student  
• Employed Employer: \_\_\_\_\_  
\*Referred By: \_\_\_\_\_

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Ethnicity: Hispanic or Latino / Other Preferred Language: \_\_\_\_\_  
Race: Asian / African Am. / Am. Indian or Alaskan Native /  
Other / Native Hawaii or Pacific Island / White Smoking Status: Every Day / Some Days / Former / Never

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**EMERGENCY CONTACT INFORMATION**

Full Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_  
Relationship: Child / Parent / Spouse / Other: \_\_\_\_\_

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**FINANCIAL INFORMATION**

• Insurance • Worker's Comp • Self-Pay (Cash) • Personal Injury/Auto • Other (please explain): \_\_\_\_\_

PRIMARY INSURANCE

Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other  
*Other than Self:*  
Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SECONDARY INSURANCE

Name: \_\_\_\_\_  
Relation to Insured: Self / Spouse / Parent / Child / Other  
*Other than Self:*  
Insured's Name: \_\_\_\_\_ Gender: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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Who is responsible for payment? Self / Other -(Relationship) \_\_\_\_\_  
*Other than Self:*  
Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Patient No: \_\_\_\_\_

# PATIENT CASE HISTORY

## HISTORY OF CURRENT CONDITION

Describe Major Complaint: \_\_\_\_\_

Began When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Describe how this began: \_\_\_\_\_

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

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: \_\_\_\_\_

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) \_\_\_\_\_

Head - Base of Skull / Forehead / Sides-Temple R / L / Both Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both Other Area: \_\_\_\_\_

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: \_\_\_\_\_

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: \_\_\_\_\_

Which daily activities are being affected by this condition? (Describe) \_\_\_\_\_

**For this CURRENT condition, have you:**

• Received any other treatment? None / DC / MD / PT / Massage / ER/ Other: \_\_\_\_\_ Where? \_\_\_\_\_

• Had any previous Surgery or Interventions in this area? (Describe) \_\_\_\_\_

• Taken any Medications? OTC / Prescriptions \_\_\_\_\_

• Had any diagnostic testing? X-rays / MRI / CT / Other: \_\_\_\_\_ When and Where? \_\_\_\_\_

Describe any Secondary Complaints: \_\_\_\_\_

## HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

### Medications:

Allergies to Medications: **NONE** (List) \_\_\_\_\_

Current Medications: **NONE**

(Already have a list? We can make a copy.) \_\_\_\_\_

Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: **NONE**

Major Injuries/Traumas: **NONE** \_\_\_\_\_

Major Hospitalizations: **NONE** \_\_\_\_\_

Patient No: \_\_\_\_\_

### Family Health History:

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

### Social and Occupational History:

Level of Education Completed: \_\_\_\_\_

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

### Habits:

Cigarettes – (#/day) \_\_\_\_\_

Alcohol – (amount/day) \_\_\_\_\_

Coffee/Tea – (cups/day) \_\_\_\_\_

Rec. Drugs (List) \_\_\_\_\_

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## REVIEW OF SYSTEMS

Are you currently experiencing any of these symptoms? (Check all that apply)

**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

### General: (constitutional)

- Recent Weight Change
- Fever
- Fatigue
- *None in this Category*

### Musculoskeletal:

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems \_\_\_\_\_
- Leg Problems \_\_\_\_\_
- Painful Joints
- Stiff/Swollen Joints
- Sore/Weak Muscles or Joints
- Muscle Spasms/Cramps
- Broken Bones \_\_\_\_\_
- Other: \_\_\_\_\_
- *None in this Category*

### Neurological:

- Numbness or tingling sensations
- Loss of Feeling
- Dizziness or light headed
- Frequent or Recurrent Headaches
- Convulsions or seizures
- Tremors
- Stroke
- Have you ever had a head injury?
- Ever been in an auto accident?
- Other: \_\_\_\_\_
- *None in this Category*

### Mind/Stress:

- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other: \_\_\_\_\_
- *None in this Category*

### Genitourinary:

- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination
- Change in force/strain w Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other: \_\_\_\_\_
- *None in this Category*

### Gastrointestinal:

- Loss of Appetite
- Blood in Stool
- Change in Bowel Movements
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other: \_\_\_\_\_
- *None in this Category*

### Cardiovascular & Heart:

- Chest Pains
- Rapid or Heartbeat changes
- Blood Pressure Problems
- Swelling of Hands, Ankles, or Feet
- Heart Problems
- Other: \_\_\_\_\_
- *None in this Category*

### Respiratory:

- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems
- Other: \_\_\_\_\_
- *None in this Category*

### Eyes and Vision:

- Wear contacts/glasses
- Blurred or double vision
- Glaucoma
- Eye disease or injury
- Other: \_\_\_\_\_
- *None in this Category*

### Ears, Nose and Throat:

- Bleeding gums / mouth sores
- Bad Breath or bad taste
- Dental Problems
- Swollen throat or voice change
- Swollen glands in neck
- Ringing in the ears
- Ear - Ache/Ringing/Drainage
- Sinus / Allergy problems
- Nose Bleeds
- Hearing Loss
- Other: \_\_\_\_\_
- *None in this Category*

### Endocrine, Hematologic, and

#### Lymphatic:

- Thyroid problems
- Diabetes
- Excessive Thirst or urination
- Cold Extremities
- Heat or Cold intolerance
- Change in hat or glove size
- Dry skin
- Glandular or hormone problem
- Swollen Glands
- Anemia
- Easily Bruise or Bleed
- Phlebitis
- Transfusion
- Immune system disorder
- Other: \_\_\_\_\_
- *None in this Category*

### Skin and Breasts:

- Rash or Itching
- Change in Skin Color
- Change in hair or nails
- Non-healing sores
- Change of appearance of a mole
- Breast Pain
- Breast Lump
- Breast Discharge
- Other: \_\_\_\_\_
- *None in this Category*

### Women Only:

#### **Are you pregnant?**

• **Yes - Due Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

• **No - Last Menstrual Period**

\_\_\_\_/\_\_\_\_/\_\_\_\_

- Infertility
- Painful or Irregular periods
- Vaginal Discharge
- Other: \_\_\_\_\_
- *None in this Category*

#### **Pregnancies with Outcome & Date:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient No: \_\_\_\_\_



## Welcome to Balanced Wellness Chiropractic!

### Appointment Reminders Preferences:

This office utilizes text messages sent to your mobile phone number that we have on file. We use these to communicate important information such as appointment reminders, office closings due to weather, etc. We will not transmit any protected health information (PHI) via text. Please let us know if you would like to opt out of communicating with our office via text message at any time.

### HIPAA Notice:

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature: (parent if minor) \_\_\_\_\_ Date: \_\_\_\_\_

### Informed Consent for Chiropractic &/or Acupuncture Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or of said minor) by Balanced Wellness Chiropractic Physicians and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. In the practice of acupuncture there are some risks to treatment, including but not limited to minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, and stuck or bent needles. **Acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process.** I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature: (parent if minor) \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Policy

Dear Patient:

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

- Payment for services is due at the time services are rendered.
  - We accept cash, checks, Visa, MasterCard, Discover, and American Express.
  - We will be happy to assist you with applying for financing should you so desire. We do not handle any financing “in house” but we do have financing available through Care Credit.
  - We reserve the right to collect before services are rendered.
- All charges are your responsibility whether the insurance company pays or not.
  - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
  - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
  - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service and or supply is denied, we may require you to follow up with your insurance and/or pay the balance due.
- Unless you are insured by Medicare or an insurance group which our doctors are participating members, or double insured (for procedure being performed), it is our policy to collect 100% payment at the time the services are rendered.
- If you are a member of an HMO or Managed Care Program or have a PCP (Primary Care Physician), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your agreement with your insurance company.
- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems, so that we may assist you in the management of your account. You may reach an Account Manager at (405) 246-0180.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

\_\_\_\_\_  
Patient's or Guarantor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Patient No: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Appointment Reminders and Health Care Information Authorization**

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that...

***(Please place a line through any method that you REFUSE to be contacted by and initial.)***

I may be *contacted* by:                      phone at home or work, mobile phone, e-mail, or postcard.  
Email: \_\_\_\_\_

*Messages* may be left:                      on answering machine/voicemail at home, work, and on mobile phone. Or with *individuals answering my phone* at home, or at work.

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date below and expires seven years from the date I last received services in this office.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized provider representative

\_\_\_\_\_  
Personal representative Printed

\_\_\_\_\_  
Personal representative signature

\_\_\_\_\_  
Description of personal representative’s authority to act for the patient.