BACKCOUNTRY RELIEF

health at new heights

Patient Demographic Information:

*Name:*_____

First *M.I* *Last*

*Preferred Name:*_____

*D.O.B:*_____ *Age:*_____

*S.S.N:*_____ *Height:*____*ft.* _____*in.*
*Weight:*_____*lbs.*

*Gender:*_____

*Address:*_____

*City:*_____ *State:*_____ *Zip:*_____

*Email*_____

*Mobile Phone*_____ *Other Phone*_____

Do we have your permission to leave you a detailed voicemail? (Please Circle One) ***YES NO***

Marital Status: **Married Single Divorced Separated Widowed Other** (*circle one)*

*Who may we thank for referring you to our office?:*_____

Who are we authorized to speak with regarding your healthcare information? *(optional)*

*Name:*_____ *Relationship:*_____

Who may we contact in an emergency? _____

*Relationship:*_____ *Phone Number:*_____

Patient Employer Information (if applicable):

Employer:_____

Occupation:_____

Personal Health History:

Name of Primary Care Provider:_____

Have you had previous chiropractic care? **Yes No**

Are you currently pregnant or planning to be? **Yes No**

Please list all medication (including over the counter) currently taken or prescribed:

(Or provide a
list):_____

_____

Please list all supplements, vitamins, or herbs currently taken: (Or provide a list)

_____

Allergies:_____

Previous Fractures (include approximate dates):

_____

Major Sprains/Strains/Falls (include approximate dates): _____

Previous Surgeries (include approximate dates): _____

Previous Cancer Diagnoses (include approximate dates):_____

Have you ever had a stroke? **Yes No**

Have you ever been struck unconscious? **Yes No**

Do you consume alcoholic beverages? **Yes No # of drinks___/week**

Do you consume caffeine? **Yes No # of drinks____/day**

Do you use tobacco/nicotine products? **Yes No # of cans or packs_____/day**

Do you use recreational drugs? **Yes No Please Specify_____**

Do you exercise? **Yes No Times a week_____**

Type of exercise:_____

Family Health History :

Have any family members been diagnosed with these health conditions?

(*Circle all that apply)*

Arthritis Cancer High Blood Pressure Kidney Disease High Cholesterol

Stroke **Heart Attack** **Autoimmune Diseases** **Neurological Diseases** **Diabetes** **Scoliosis**

Other:_____

Health Problems + Concerns

(Please circle all that apply to your current or past health history)

Alcoholism	Dizziness	Loss of Taste
Anemia	Epilepsy	Lung Disease
Arteriosclerosis	Excessive Menstruation	Macular Degeneration
Arthritis	Eye pain or Issues	Mental Health Disorder
Asthma	Fatigue	Migraines
Autoimmune Disease	Frequent Urination	Nosebleeds
Back Pain	Gallbladder Disease/Stones	Pacemaker
Bleeding Disorders	Glaucoma	Parkinson’s
Breast Lump	Gout	Polio
Bronchitis	Headache	Prostate Problems
Bruise Easily	Hemorrhoids	Retinal Disease
Cancer	Hot Flashes	Sciatica
Cataracts	High Blood Pressure	Seizures
Chest Pain	High Cholesterol	Shortness of Breath
Cold Extremities	Irregular Heart Beat	Sinus Infection
Constipation	Irregular Menstrual Cycles	Sleep Problems/Apnea
COPD/Emphysema	Kidney Infections	Skin Sensitivity
Cramps	Kidney Stones	Smoker Previous/Current
CVA/Stroke/TIA	Liver Disease	Spinal Curves/Scoliosis
Dementia/Alzheimer’s	Loss of Memory	Swollen Ankles
Diabetes	Loss of Balance	Swollen Joints
Digestive issues	Loss of Smell	Tourette’s Syndrome

Thyroid Condition Ulcers Other:_____

Tuberculosis Varicose Veins

Current Condition:

Reason for today's visit:

_____

How long have you had this condition?

_____

Is this condition due to a motor vehicle collision? **Yes No**

Is this condition due to a work-related injury? **Yes No**

Have you had imaging (X-ray, MRI, ect.) of this complaint? **Yes No**

If yes, where? _____

In your arms or legs do you have?: *(Please circle all that apply)*

Radiating Pain Numbness Tingling Weakness

Please rate your pain 0-10 (0=no pain, and 10=worst pain imaginable): _____



How often do you have this pain? **Comes and Goes Constant**

Type of pain: (Please circle all that apply)

Dull Aching Sharp Tightness/Stiffness Shooting Burning Tingling Other:_____

What makes your pain worse? (Please Circle)

Bending Twisting Lifting Sitting Standing Laying Walking Working Chores Driving Turning Exercising Getting out of bed Other: _____

What makes your pain better? (Please Circle)

Resting Sitting Standing Walking Sleep Exercise Medicine Laying Chiropractic

Massage Acupuncture Redirected Attention Other:_____

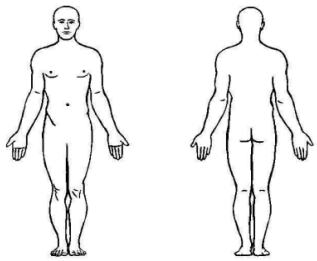
What other treatments have you tried? (Please Circle)

Prescription Medication Over-the-counter Medication Physical Therapy Massage

Chiropractic Acupuncture Injections Surgery Mental Health Services

Other:_____

Please mark on the body chart where you are experiencing pain →



Consent to Treatment

I acknowledge that I have voluntarily sought chiropractic care at this clinic and authorize the Doctor to perform examinations, diagnostic procedures, chiropractic adjustments, spinal decompression, electrical stimulation (e-stim), and other associated procedures as deemed necessary for my care. I understand the nature, purpose, and potential risks of these treatments.

Signature: _____*Date:*_____

(Patient, Parent or Guardian, if Minor)

Payment Agreement

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred I, the undersigned, have insurance and or/employee health care benefits coverage with the below captioned and hereby assign and convey directly to **BackCountry Relief LLC,** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** ***I hereby authorise the doctor to release medical information necessary to process this claim.***

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to such doctor any and all plan documents, insurance policy, and/or plan settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursements or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claims submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan, any claim, chose in action, or other right I may have to such insurance and and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to to medical expenses incurred as a as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such benefits, insurance reimbursement and any applicable remedies.

Further in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action right against my insurers and/or employee health care plan, including if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should reasonably be expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. *A photocopy of this assignment is to be considered as valid as the original*. **I have read and fully understand this assignment.**

I agree with the above statement and will be paying with:

☐ Private Insurance ☐ Medicare / Medicaid ☐ Cash / Check / Credit or Debit Card

SIGNATURE:_____Date:__/__/___

(Patient/ Insured/ Parent or Guardian)

I have been given a copy of the HIPPA Notice to read.☐