

BACK TO HEALTH CHIROPRACTIC REGISTRATION FORM

Date _____ Home Phone _____ Cell Phone _____

Email _____

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birth date _____

Are you: Single Married Widowed Separated Divorced

Who referred you to this office? _____

PARENTAL CONSENT TO EVALUATE AND TREAT A MINOR

I _____, being the parent/legal guardian of _____
hereby grant permission for my child to receive chiropractic care.

Witness _____

CONSENT TO INITIATE CARE

At our office, we have one simple goal – we want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over these procedures below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please direct them to the receptionist.

- ☼ You may choose to submit receipts to your insurance company or other third-party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take *no responsibility* for non-payment by insurance companies for services rendered at our office.
- ☼ Our office will not respond to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. However, patients may have a copy of their records and the original x-rays at any time they request.
- ☼ No balances can be kept or run by patients at any time.
- ☼ All adjustment visits are paid immediately *prior* to the service being rendered.
- ☼ All initial visits and x-rays are paid for upon *completion* of these services.
- ☼ Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. In understand that I am under no obligation to receive or continue care.

Print your name _____ Today's Date _____

Sign your name _____

WORK INJURY AND AUTOMOBILE INJURY NOTICE

(Every new patient must sign and date this page)

1. Work Injuries:

By signing below, I acknowledge that I am aware that **Back To Health Chiropractic and Dr. Jay Korsen do not provide care for work related injuries**. I also acknowledge that I must inform this office if I am in a work related injury and I understand that I must seek care at my medical doctor's office or another healthcare provider for injuries of conditions sustained at work. I also am completely aware that Back To Health Chiropractic and Dr. Jay Korsen will not bill, submit claims, nor prepare or submit reports for any work related injury.

2. Automobile accidents/ Personal Injuries:

It is the experience of Back To Health Chiropractic and Dr. Jay Korsen, over the past two decades of practice, that Insurance companies, lawyers and the physicians the insurance companies hire to lie on their behalf have corrupted the personal injury system. As a result, we can no longer be a part of this charade. **Back To Health will not bill Any Insurance including your auto or health insurance following a motor vehicle accident or personal injury**. I am aware that if I chose to be treated at Back To Health Chiropractic for injuries sustained in an accident, I will be responsible for the full private pay fee at the time of service until I have reached maximal medical improvement of my injuries. I further acknowledge that my attorney and I are entitled to a copy of my hand written daily treatment records but if my attorney or my insurance carrier requires a doctor's report or narrative, the fee for each report or narrative is two hundred-fifty (250) dollars paid in advance. This fee is usual and customary, as each report requires about an hour to an hour and a half of the doctor's time.

Signed: _____

(Please Print Name): _____

Date: _____

SOME QUESTIONS TO HELP US HELP YOU

NAME: _____ DATE: _____

If we could only help you with one health problem, what would that be?

What other health problem would you like us to help you with?

How did these problems start?

When did these problems begin?

Have you ever had these problems before?

Is it worse in the morning or at night (check one)? Morning _____ or Night _____

Do you ever have numbness, tingling or pain in the arms or legs?

How often do you feel the pain and how long does it last?

Please list any other doctors seen for the above problem:

Please list medications you are currently taking:

Please list any surgeries you have had:

Please list any auto or work accidents you have had:

Please circle any in your family history: Heart disease – Diabetes – Arthritis – Cancer – Back problems

Do you get any dizziness (circle one)? Yes /No

Do you have heart, lung or stomach problems (circle one)? Yes/No

Are you right or left-handed?

How tall are you?

How little do you weigh?

Name of previous chiropractor:

When were the last X-rays of your spine taken?

Are you looking for temporary relief or do you want the cause of your problem fully corrected?

Why?

What activities or hobbies have you been unable to do because of your problem?

MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast

Are you pregnant?
 Yes No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

CARDIO-VASCULAR-RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problem
- Heart problems
- Lung problems
- Varicose veins

EYE, EARS, NOSE, THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

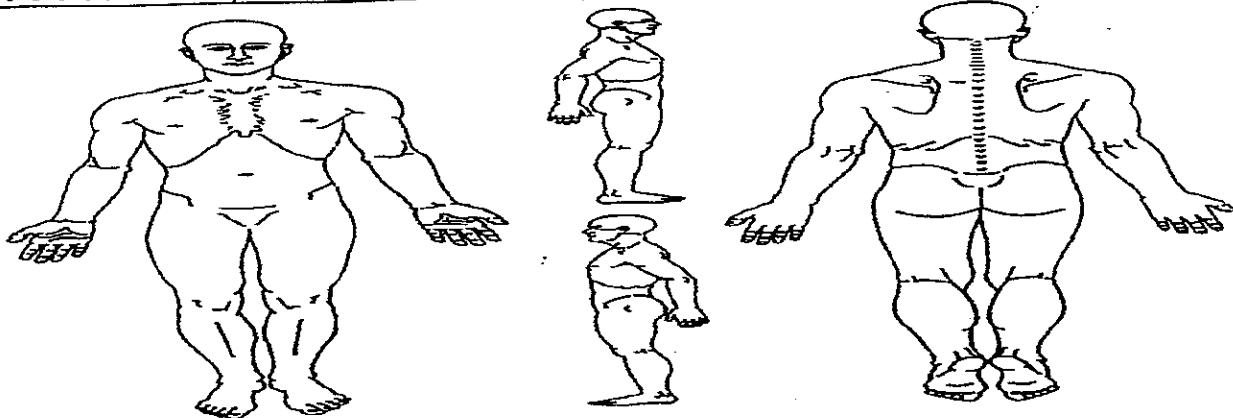
Signed: _____

(Please Print Name): _____

Date: _____

Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache >>>>>	Numbness =====	Pins and Needles ↓↓↓↓↓	Burning ×××××
Stabbing ∇∇∇∇∇	Throbbing ~~~~~	Tingling +++++	Sharp ↔↔↔↔↔
Dull 0 0 0 0 0	Soreness ○○○○○	Shooting ⊕ ⊕ ⊕ ⊕	Other



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort severity, please circle.

What is your pain/discomfort like today? No Pain -0-1-2-3-4-5-6-7-8-9-10 Severe Pain

What is your least pain/discomfort? No Pain -0-1-2-3-4-5-6-7-8-9-10 Severe Pain

What is your worst pain/discomfort? No Pain -0-1-2-3-4-5-6-7-8-9-10 Severe Pain