Back to Health Chiropractic ◆ 3075 West 7800 South, West Jordan UT 84088 ◆ 801 565-9500

CONFIDENTIAL PATIENT INFORMATION

Name: ________________________ Social Security #: ______-____-________ Home phone : ___________________

Address: ____ Cell Phone: ___________________

Best telephone number to reach you during the day: ☐ Cell ☐ Work ☐ Home ☐ Other: ___________________________

Email: _________________________ Age: _____ DOB: __________ Height: ________ Weight: ______ Sex: ☐ M ☐ F

marital Status: ☐ S ☐ M ☐ W ☐ D How many Children: _________ Referred to our office by: ___________________

Occupation: _______________________________ Employer: ______________________ Phone: ___________________

Spouse Name: ____________________________ Employer:______________________ Phone: ___________________

Emergency Contact: _________________________ Relation: _____________________ Phone: ___________________

Health History

Main symptom(s) you feel: _________________________________ Average Pain Level: 0-10 (10 being worst) _______

What caused your condition: ☐ Auto Accident ☐ Work Accident ☐Overexertion, Lifting Pulling, Etc.

☐ Repetitive Movement/Posture ☐ Fall/Trip/Slip Where? ☐ Gradual Onset ☐ Other _________________________

Date symptom(s) appeared: _________________________________ Are symptoms: ☐ Better ☐ Worse ☐ Same

Have you seen a doctor about this? ☐ Y ☐ N Name: __________________________ When: ____________________

Have you had or do you currently have: ☐ Neuropathy ☐ Strokes ☐ Fainting Spells ☐ Back Surgery

Do you have any family history of: ☐ Back Pain ☐ Arthritis ☐ Headaches ☐ Diabetes

Do you smoke: ☐ Y ☐ N __________ packs per day. Do you drink alcohol: ☐ Y ☐ N __________ times per week.

Injuries or surgeries: ____ Dates: ________________

Current medications: ____ Are you pregnant: ☐ Y ☐ N

The information I have provided is accurate and I know it will be used to determine appropriate chiropractic care. I authorize the performance of X-rays and all of their diagnostic and therapeutic procedures for myself and/or for my dependent(s). I acknowledge receipt of the Notice of Privacy Practices. I also give my consent to receive important email correspondence from this office.

Signature of responsible party: ____ Date: ____________________

system which could affect the structures, organs, and functions listed under "areas" and the "possible symptoms" that are associated with malfunctions of the areas noted.

5-9500

Vertebrae	Areas & Parts of Body	Possible symptoms
C1	Blood supply to the head, pituitary gland scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	❑ Headaches ❑ nervousness ❑ insomnia ❑ head colds ❑ high blood pressure ❑ migraine headaches ❑ nervous breakdowns ❑ amnesia ❑ chronic tiredness ❑ dizziness
C2	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	❑ Sinus trouble ❑ allergies ❑ pain around the eyes ❑ earache ❑ fainting spells ❑ certain cases of blindness ❑ crossed eyes ❑ deafness
C3	Cheeks, outer ear, face bones, teeth, trifacial nerve.	❑ Neuralgia ❑ neuritis ❑ acne or pimples ❑ eczema
C4	Nose, lips, mouth, eustachian tube.	❑ Hay fever ❑ runny nose ❑ hearing loss ❑ adenoids
C5	Vocal cords, neck glands, pharynx.	❑ Laryngitis ❑ hoarseness ❑ throat conditions such as sore throat or quinsy
C6	Neck muscle, shoulders, tonsils.	❑ Stiff neck ❑ pain in upper arm ❑ tonsillitis ❑ chronic cough ❑ croup
C7	Thyroid gland, bursae in the shoulders, elbows.	❑ Bursitis ❑ colds ❑ thyroid conditions
T1	Arms from the elbows down, including hands, wrists, and fingers, esophagus and trachea.	❑ Asthma ❑ cough ❑ difficult breathing ❑ shortness of breath ❑ pain in lower arms and hands
T2	Hear, including its valves and covering, coronary arteries.	❑ Functional heart conditions and certain chest conditions
T3	Lungs, bronchial tubes, pleura, chest, breast.	❑ Bronchitis ❑ pleurisy ❑ pneumonia ❑ congestion ❑ influenza
T4	Gallbladder, common duct.	❑ Gallbladder conditions ❑ jaundice ❑ shingles
T5	Liver, solar plexus, circulation (general).	❑ Liver conditions ❑ fevers ❑ blood pressure problems ❑ poor circulation ❑ arthritis
T6	Stomach.	❑ Stomach troubles including: ❑ nervous stomach ❑ indigestion ❑ heartburn ❑ dyspepsia ❑
T7	Pancreas, duodenum.	❑ Ulcers ❑ gastritis
T8	Spleen.	❑ Lowered resistance
T9	Adrenal and suprarenal glands.	❑ Allergies ❑ hives
T10	Kidneys.	❑ Kidney troubles ❑ hardening of the arteries ❑ chronic tiredness ❑ nephritis ❑ pyelitis
T11	Kidneys. ureteres.	❑ Skin conditions such as acne ❑ pimples ❑ eczema ❑ boils
T12	Small intestines, lymph circulation.	❑ Rheumatism ❑ gas pains ❑ certain types of sterility
L1	Large intestines, inguinal rings.	❑ Constipation ❑ colitis ❑ dysentery ❑ diarrhea ❑ some ruptures or hernias ❑
L2	Appendix, abdomen, upper leg.	❑ Cramps ❑ difficult breathing ❑ minor varicoses veins
L3	Sex organs, uterus, bladder, knees.	❑ Bladder troubles ❑ menstrual troubles such as painful or irregular periods ❑ miscarriages ❑ bed wetting ❑ impotency ❑ change of life symptoms ❑ many knee pains
L4	Prostate gland, muscles of the lower Back, sciatic nerve.	❑ Sciatica ❑ lumbago ❑ difficult painful or too frequent urination ❑ backaches
L5	Lower legs, ankles, feet.	❑ Poor circulation in the legs ❑ swollen ankles ❑ weak ankles and arches ❑ cold feet ❑ weakness in the legs ❑ leg cramps
SACRUM	Hip bones, buttocks.	❑ Sacroiliac conditions ❑ spinal curvatures
COCCYX	Rectum, anus.	❑ Hemorrhoids (piles) ❑ pruritus (itching) ❑ pain at end of spine on sitting

	Greatly disturbed (3-5 hours sleepless)	4
	Completely disturbed (5-7 hours sleepless)	5
My recreation activities	Cause no pain	0
	Cause some pain	1
	Cannot do all of them because of pain	2
	Can only do a few of them because of pain	3
	Can hardly do any of them because of pain	4
	Can't do any at all	5

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%

YOUR TOTAL POINTS ____

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PATIENT TO DOCTOR CHIROPRACTIC CARE EXPECTATION ACKNOWLEDGEMENT

It is important for our office to fully understand the expectations of our patients. And, for our patients to fully know the stages of chiropractic care we offer. Please fill out the questionnaire below to help us better understand your needs.

There are essentially three stages of chiropractic care, place a check mark next to each type care you are seeking;

_____ **Yes I want; Acute care / Pain Relief: Phase I**

The goal is to relieve immediate pain and improve function of the spine.
Remove the nerve interference at the spinal segments minimizing the spasms in the muscles. Spinal alignments should not be expected to stay for more then 1-2 days in this limited time of care, but towards the end of the first phase of care your pain will be drastically eliminated. * Appointments are more frequent during this phase of care.

_____ **Yes I want; Rehabilitative Care / Spinal Correction: Phase II**

The goal is to continue the healing process, help prevent any relapses, and eliminate pain as much as possible at this point. Adjustments are beginning to hold for 2-4 days at this phase. Another **very important goal** is retrain your spine proper alignment with muscle memory from consecutive spinal adjustments, and break up scar tissue.
* Appointments begin to space out.

_____ **Yes I want; Retainer Spinal Care: Phase III**

This phase of care is just like wearing a retainer after braces.

The goal is to have retrained your spine to hold proper alignment, help eliminate nervous system interference and allow your body to perform with optimized function and movement. This allows you to stay in the best health of your life.

* Appointments are commonly once a month or once every few months.

Activities of Daily Living – How does your condition interfere with life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting					Grocery Shopping				
Rising out of chair					Household chores				
Standing					Lifting objects				
Walking					Reaching overhead				
Lying down					Showering/bathing				
Bending over					Dressing				
Climbing Stairs					Rolling in bed				
Using a computer					Getting to sleep				
Getting in/out of a car					Staying asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				

Patient Name: ____ Date: _____/_____/_______

Patient Signature: ____ Date: _____/_____/_______

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BACK TO HEALTH CHIROPRACTIC PRIVACY POLICY:

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations. You may revoke this consent at any time by notifying BHC in writing except to the extent BHC has taken action and reliance on your consent.
Please refer to the Notice of Privacy Practices for Protected Health Information (Privacy Notice) for a more complete description of the uses and disclosures that BHC may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.
In accordance with the law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by re question a notice in person.
You have the right to request BHC to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. BHC is not required to agree to requested restrictions. If BHC agrees to the requested restriction, BHC will honor the request and it will be binding on the office.

I hereby consent to the use and disclosure by Back to Health Chiropractic, its workforce, and its business associates of my protected health information for the purposes of treatment, payment, and health care operations.

I ____(print name) do here by give Back to Health Chiropractic permission

for 1:____________________________2: _______________________________3:______________________________
to receive patient medical records and accounting information on my behalf.

Dates effective: ______/______/__________ *to* ______/______/__________

Patient Name: ____

Patient Signature: _____________________________________ *Date:* _________________________

BHC Employee: _______________________________________ *Date:* _________________________

DR. CHRISTENSEN NPI: 1588976195 TAX ID: 47-4702194

INSURANCE VERIFICATION FORM

Back to Health Chiropractic ◆ 3075 West 7800 South, West Jordan UT 84088 ◆ 801 565-9500

Member ID: ____
Insurance Company: ____ **Phone #:** _________________________
Address: ____ **City:** ________________ **State:** ______ **Zip:** ____________
Guarantors Name: ______________________________________ **DOB:** ____________ **ID #** ______________________
Address: ____ **Phone #:** ________________________
Patient name: ____ **DOB:** ___________ **SS#** _____________________
Address: ____ **Phone #:** _________________________

FOR OFFICE USE ONLY

Are we a provider: □ YES □ NO IF NO; are there out of network benefits? □ YES □ NO
Policy effective Date : ___________ Calendar year: ______ to ______ Carry over: YES NO
Medical Deductible (person): $_______ met: $_________ Family $________ met $ ________
Chiro. Deductible (person): $_________ met: $_________ Family $________ met $ ________
Chiro Coverage: NO / YES, paid at _____%; Co-insurance: _______%; co-pay: $ ______/ visit
Yearly limits: # of visits _______ used so far: ________(OR) $ amount_______ used: ________
Limitations on policy: ____
Accidental coverage for slips and falls outside of regular benefits?: NO YES
If YES coverage: ____
Is PCP referral required?: NO YES PCP: ______________________ **phone #** _______________
Is Pre-Authorization required?: NO YES: ____

CPT code	Processed under	Allowed YES NO	# allow per day & year
NP 99201 to 99204	Medical / Chiro.	YES NO *Medicare	Day: Year:
RE 99213 to 99214	Medical / Chiro.	YES NO *Medicare	Day: Year:
Adj. 98940 to 98943	Medical / Chiro.	YES NO	Day: Year:
X-rays all 7 codes	Medical / Chiro.	YES NO *Medicare	Day: Year:
PT codes all 97 codes	Medical / Chiro.	YES NO *Medicare	Day: Year:
Medicare ABN Disclaimer:			

ASSIGNMENT OF BENEFITS:
I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Back to Health Chiropractic.

RELEASE OF INFORMATION:
I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare.

PAYMENT AGREEMENT:
I understand that there is no guarantee that my insurance companies, pre-paid health plan, or Medicare will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

My annual deductible: $____________ amount met for 2017: $__________ remainder: $_____________
My approximate per visit co-pay $ __________ (X) # visits needed ________ = Total $____________

Patient Signature: ____________________________________ Date: _____________________

Back to Health: ______________________________________ Date: _____________________