BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Name: _____ Pronoun: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ cell/home Appointment Reminders: **Text or Email?**

Email Address: _____ Social Security Number: _____

Spouse/Significant Other's Name: _____ Phone # _____

Sex: *M F* Marital Status: *M S D W* Children: ____ Your Date of Birth: _____ Age: _____

Occupation: _____

Employer: _____

Emergency Contact and Phone Number: _____

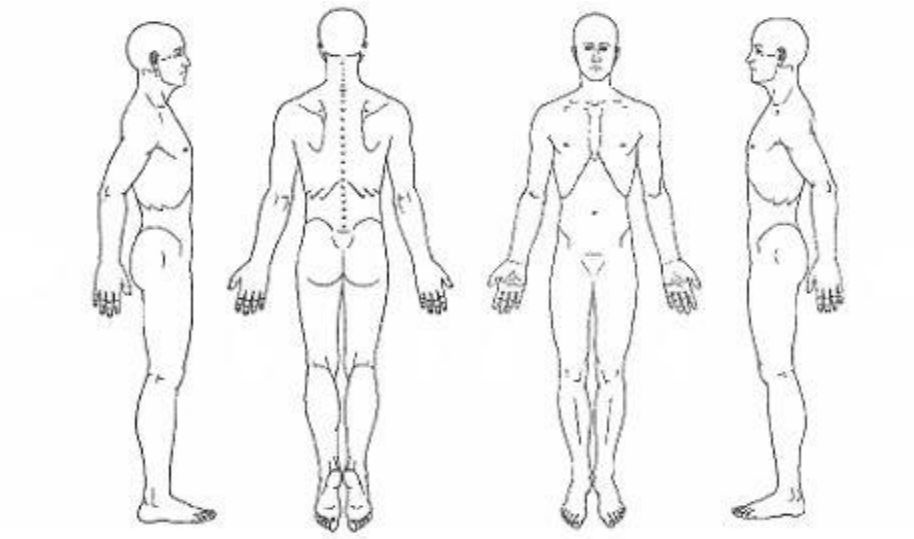
How Did You Hear About Us? (whom may we thank?)
Referred by: ☐ Family/Friend: _____ ☐ Google ☐ Yelp ☐ Social Media

☐ Health Professional: _____ ☐ Other: _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

Reasons for seeking care at Back to Health: _____
(wellness, current symptoms, your spouse made you)

Chief Complaints:



BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Symptoms:

_____

_____

_____

- On a scale from 0-10, with 10 being the worst; **what number** best describes your symptom most of the time (mark one): 1 2 3 4 5 6 7 8 9 10

- What **percentage of the time** you are awake do you experience the above symptom(s) at the above intensity (mark one):
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom(s) begin **immediately** or **gradually**? (mark one)

- Is it getting **better, worse** or the **same?** (mark one)

- When/how did the symptom(s) **begin**?
  _____

  _____

- What are you having **problems with**? (mark all that apply):
  - Seeing, hearing, reading, holding, walking, kneeling, lifting, sitting, sports, reclining, insomnia, loss of concentration, change in personality, tasting, bathing, typing, pinching, stooping, bending, pushing, driving, exercising, restful sleep, using the toilet, smelling, grooming, writing, standing, squatting, twisting, pulling, riding in car, loss of sexual drive, nervous, tactile feeling, eating, dressing, grasping, leaning, climbing, carrying, reaching, air travel, irritable, getting up from seated position, nothing, other (please describe): _____

- What makes the symptom(s) **better**? (mark all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe):
    _____

- Describe the **quality** of the symptom(s) (mark all that apply):
  - Dull, sharp, achy, shooting, spasm, throbbing, burning, numbing, tingling
  - Other (please describe): _____

- Does the symptom(s) **radiate** to another part of your body (mark one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom(s) **worse** at certain times of the day or night? (mark all that apply)
  - No difference Morning Afternoon Evening Night Other:_____

- Are you able to **sleep without** pain? yes no
  - Does it **wake** you? yes no
  - Did you have trouble sleeping **before**? yes no

BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

- Have you received **other** treatment for this condition and episode prior to today's visit?

  _____

  (NSAIDS, pain rx, muscle relaxers, trigger point injections, prolotherapy, surgery, massage, PT, chiropractic, etc.)

Please note if there is anything else about your symptom(s):

_____

_____

_____

Health History:

Past Medical History

Have you had any of the following **pulmonary (lung-related)** issues? ☐ None

Asthma	Emphysema	Other:
COPD	Other:	Other:

Have you had any of the following **cardiovascular (heart-related)** issues or procedures? ☐ None

Angina/chest pain	Heart disease/problems	Murmurs/valve disease
Congestive heart failure	Hypertension	Other:
Heart attacks/MIs	Irregular heartbeat	Other:

Have you had any of the following **neurological (nerve-related)** issues? ☐ None

Headaches	Memory loss	Vertigo
Loss of smell/taste	Seizures	Visual changes/loss of vision
One-side weakness face/body	Strokes/TIA	Other:
One-side decreased feeling in face/body	Tremors	Other:

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures? ☐ None

Diabetes	Injectable steroid replacements	Other:
Endometriosis	Painful periods	Other:
Hormone replacement therapy	Thyroid disease	Other:

Have you had any of the following **renal (kidney-related)** issues or procedures? ☐ None

Bladder infections	Hematuria (blood in urine)	Renal calculi/stones
Dialysis	Incontinence	Other:
Difficulty urinating	Kidney disease	Other:

Have you had any of the following **gastroenterological (stomach-related)** issues? ☐ None

Bloody/black stools	Gastroesophageal reflux/heartburn	Ulcerative disease
Bowel incontinence	Hepatitis/liver disease	Pancreatic disease
Constipation	Hiatal hernia	Vomiting
Difficulty swallowing	Irritable bowel/colitis	Other:
Frequent abdominal pain	Nausea	Other:

Have you had any of the following **hematological (blood-related)** issues? ☐ None

Abnormal bleeding/bruising	Hemophilia	Regular aspirin use
Anemia	HIV positive	Sickle-cell anemia

BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Anticoagulant therapy	Hypercoagulation/ DVT/blood clots	Other:
Enlarged lymph nodes	Regular anti-inflammatory use	Other:

Have you had any of the following **oncological (cancer-related)** issues? ☐ None

Abnormal bleeding/bruising	Fever/chills/sweats/unexplained weight loss	Other:
Cancer:	Other:	Other:

Have you had any of the following **dermatological (skin-related)** issues? ☐ None

Psoriatic disorders	Significant rashes	Other:
Significant burns	Skin grafts	Other:

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues? ☐ None

Arthritis (unknown type)	Metal implants	Spinal surgery
Broken bones	Osteoarthritis	Other:
Gout	Rheumatoid arthritis	Other:
Joint surgery	Scoliosis	Other:

Have you had any of the following **psychological** issues? ☐ None

Bipolar disorder	Psychiatric	Schizophrenia
Depression	Psychiatric hospitalizations	Other:
Homicidal ideations	Suicidal ideations	Other:

Is there anything else in your past medical history that you feel is important to your care here?

_____

_____

_____

Surgeries: (if applicable, write year in the adjacent box) ☐ None

Abdominal Exploration		Hernia Repair	
Abdominoplasty		Hip Replacement	
Abortion		Hysterectomy	
ACL Reconstruction		Kidney Transplant	
Adenoid Removal		Knee Arthroscopy	
Angioplasty		Knee Replacement	
Appendectomy		LASIK	
Bunion Removal		Liposuction	
Carotid Artery Surgery		Lumbar Spine Surgery	
Cataract Surgery		Mastectomy	
Cervical Spine Surgery		Prostate Removal	
Cholecystectomy		Rotator Cuff Surgery	
Cosmetic Breast Surgery		TMJ Surgery	
C-Section		Tonsillectomy	
Facelift		Vasectomy	
Gastric Bypass		Other:	
Heart Surgery		Other:	
Hemorrhoid Surgery		Other:	

BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Previous Injury or Trauma:

_____

(falls, accidents, sports, etc)

Allergies: (mark all that apply) ☐ None

Acetaminophen	Fragrance	Pollen
Adhesive Tape	Ibuprofen	Soy
Barbiturates	Insulin	Sulfa
Bee/Yellow Jacket Stings	Iodine	Tobacco Smoke
Dairy	Latex	Wheat/Gluten
Dust Mites	Mold	Other:
Eggs	Nuts	Other:
Fish/Shellfish/Seafood	Pet Dander	Other:

Family Health History: (mark all that apply) ☐ None

Cancer	Heart disease	Other:
Cardiac disease below age 40	Neurological diseases	Other:
Diabetes	Psychiatric disease	Other:
Headaches	Strokes	Adopted/Unknown

Medications: (mark if currently taking) ☐ None

Advil/NSAIDS	Gabapentin
Ambien	Statin Medications
Aspirin	Tylenol
Blood Pressure Medications	Vicodin/Other Pain Medication
Daily Vitamins	Other:
Diabetes Medications	Other:
Flexeril/Muscle Relaxers	Other:

Height: _____ Weight: _____

Social and Occupational History:

A. Job description: _____
(plus what level of satisfaction do you have in your job?)

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:
Level of Exercise: _____

Alcohol/Tobacco Use: _____

General Diet: _____

Self-care: _____

BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Informed Consent for Chiropractic Care
Effective April 2023

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive this care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one to one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient's Printed Name	Signature of Patient (guardian signature if patient is under 18)	Date
Office Staff Printed Name	Signature of Office Staff	Date

BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Notice of Privacy Practices (HIPAA Consent Form)
Effective April 2023

By signing below, I understand that some of my health information may be used/and or disclosed by Back to Health Chiropractic and Wellness to carry out treatment, payment, or healthcare operations. For a more complete description of such uses and disclosures I should refer to Back to Health Chiropractic and Wellness's privacy notice entitled "HIPAA Notice of Privacy Practices". I understand that I may view this notice any time prior to signing this form.

This notice describes how health information about you may be used and disclosed and how you can get access to this information, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:
1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain in accordance to changes in the law. All changes in this Notice will be prominently displayed and available at our office.

You have the right to:
• Get a copy of your medical record
• Correct your medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information with
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

We will never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information
• Most sharing of chiropractic and treatment notes

Our responsibilities:
• We are required by law to maintain the privacy and security of your protected health information
• We will let you know if a breach occurs that may have compromised the privacy or security of your information
• We must follow the duties and privacy practices described in this notice and give you a copy of it if requested
• We will not use or share your information other than that is described here unless you tell us in writing.

Check one:

☐ Back to Health Chiropractic and Wellness does NOT have my permission to share my information.

☐ Back to Health Chiropractic and Wellness CAN release my applicable information to _____
(name of individual)

_____ _____ _____
Patient's Printed Name Signature of Patient (guardian signature if patient is under 18) Date

BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email: renobacktohealth@gmail.com

Financial Arrangements
Effective September 2023

Please check one:

____ **SELF-PAYMENT:** I am responsible for services rendered to me and will be paid in full at the time of service unless other arrangements have been made. A $25.00 fee for returned checks to cover any fees that apply from the transaction.

____ **INSURANCE PAYMENT:** Coinsurances, copayments, deductibles and/or non-covered services are due at each appointment. Insurance benefits are checked by the staff as a courtesy, but they are not a guarantee of benefits/payment. Coinsurance, copays and other allowable information given to us is an estimate, and further payment may be required after your claim has been paid. Ultimately it is your responsibility as the patient to know your insurance coverage. Any balances remaining unpaid after 60 days may be turned over to a collection agency. A $25.00 fee for returned checks to cover any fees that apply from the transaction.

•I understand that no doctor can or should guarantee any "cure" for any course of treatment; therefore refunds for received treatment cannot be given.

•If unable to keep an appointment, as a courtesy to our staff and other patients, please give a 24-hour notice. If no attempt is made to contact Back to Health Chiropractic and Wellness before a missed appointment, we reserve the right to implement a $25.00 missed appointment charge. The patient will be responsible for payment.

I fully understand the terms of this agreement and I may receive a copy of this agreement upon my request.

Patient's Printed Name	Signature of Patient (guardian signature if patient is under 18)	Date

****EXAMS/ADDITIONAL SERVICES****

Many insurance companies follow the Medicare fee schedule, which allows for limited chiropractic coverage. Per Medicare Part B guidelines, reimbursement is permitted only for care that Medicare has defined as *CHRONIC* or *ACUTE* **spinal** misalignments and does not pay for ultrasound, electric stimulation, extremity adjustments, spinal traction, or examinations. *Medicare Benefit Policy Manual, Ch 15- Transmittal 240.1.3.* Insurance (not a complete list**): Medicare Part B** (even with secondary), **Ambetter, Prominence Commercial, TrustFund & Senior Care Plus** are plans that often do not cover these. Some Medicare Advantage plans do cover these and we can check as a courtesy.

Besides office exams, medically necessary, but non-covered therapies may be provided in our office if agreed upon beforehand, and will be subject to a self-pay discount at the time of service. Paying at the time of service allows us to discount the cost of the treatment that would otherwise be billed to the insurance at a different rate. This fee helps cover the cost of materials and wear/tear on the equipment.

• New Patient Office Exams	$70.00
• Re-examinations (if not seen in 1+ years/new injury, doctor discretion)	$25.00
• Additional Services (US, stim, traction, extremity adjustments)	$10.00

Patient's Printed Name	Signature of Patient (guardian signature if patient is under 18)	Date