NEW PATIENT INFORMATION

PATIENT INFORMATION

Date____/____/____

Name:_____
LAST FIRST

Address:_____ City:_____ State:_____

Zip:_____

Home Phone:(____)_____

Work Phone:(____)_____

Cell:(____)_____

Email:_____
Would you like to receive our newsletter? YES NO

Occupation:_____ Employer:_____

Work Status: Full-Time Part-Time Self-Employed Unemployed Off-Work Student

Date of Birth:_____/_____/_____ Age:_____ Gender: Male Female

Marital Status: Single Married Divorced Widowed Children: Yes No

Spouse's Name:_____ Phone:(____)_____

Spouse's Employer:_____ Phone:(____)_____

Emergency
Contact:_____Phone:(____)_____

Whom may we thank for referring
you?_____

PATIENT CONDITION

Describe your major complaint(s):_____

_____

Date you first noticed symptoms:_____ Describe how they began:_____

_____

Have you had these symptoms before? YES NO If yes, when:_____

How often do you experience the symptoms?

Constantly (76%-100% of the day)
Frequently (51%-75% of the day)
Occasionally (26%-50% of the day)
Intermittently (0%-25% of the day)

How would you describe the symptoms?

Sharp	Shooting	Stabbing	Weakness
Dull	Burning	Stiffness	Throbbing
Numb	Tingling	Cramps	Achy

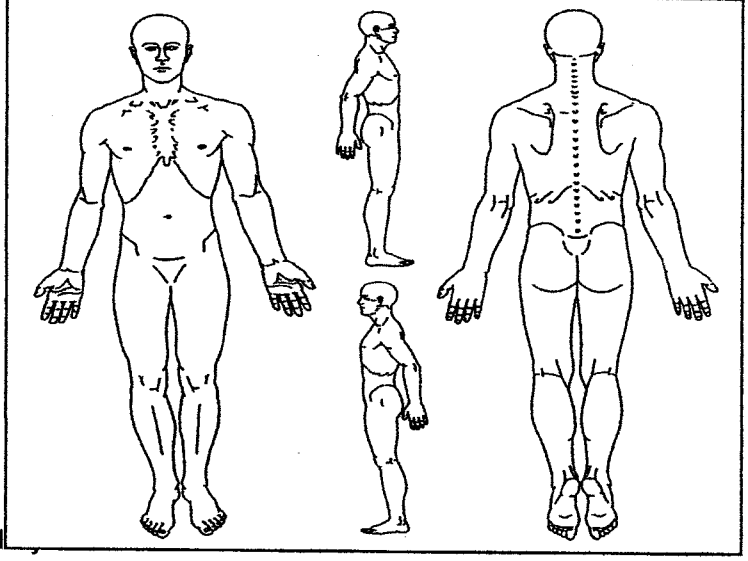
How are your symptoms changing?

Getting Better Getting Worse No Change

How would you rate your symptoms at their:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK BELOW WHERE YOU HAVE SYMPTOMS



How do your symptoms affect your ability to perform d

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

What makes your symptoms worse?_____

What makes your symptoms better?_____

Have you seen any other health care professionals for this condition? YES NO If yes, list the providers:

Name: Address: Date:

_____

_____

Have you had any tests done for your symptoms? YES NO If yes, please check test and give date.

X-Rays_____ CT Scan_____ MRI_____ Lab_____ Other_____

Please indicate findings if known:_____

Have you seen any other health care professionals for any other condition? YES NO If yes, please list:

Name: Address: Date:

_____

_____

Have you ever received chiropractic care before? YES NO If yes, please list:

Name: Address: Date:

_____

_____

HEALTH HISTORY

Place a mark on "Yes" or ""No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Dizziness	Yes	No	Hypertension	Yes	No	Psychiatric Care	Yes	No
Alcoholism	Yes	No	Eating Disorder	Yes	No	Kidney Disease	Yes	No	Rheum. Fever	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Liver Disease	Yes	No	Ringing in Ears	Yes	No
Ankle Swelling	Yes	No	Excessive Thirst	Yes	No	Loss of Balance	Yes	No	Shortness of		
Arthritis	Yes	No	Fainting	Yes	No	Loss of Sleep	Yes	No	Breath	Yes	No
Asthma	Yes	No	Fatigue	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Bleeding			Fever	Yes	No	Mononucleosis	Yes	No	Thyroid		
Disorder	Yes	No	Fractures	Yes	No	Multiple			Problem	Yes	No
Bowel/Bladder			General			Sclerosis	Yes	No	Tuberculosis	Yes	No
Changes	Yes	No	Stiffness	Yes	No	Nausea	Yes	No	Tumors	Yes	No
Breast Lump	Yes	No	Glaucoma	Yes	No	Night Sweats	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Goiter	Yes	No	Numbness	Yes	No	Unintentional		
Chemical			Gonorrhea	Yes	No	Osteoporosis	Yes	No	Weight Change	Yes	No
Dependency	Yes	No	Gout	Yes	No	Pacemaker	Yes	No	Vaginal		
Chest Pain	Yes	No	Headaches	Yes	No	Pinched Nerve	Yes	No	Infections	Yes	No
Chronic Cough	Yes	No	Heartburn	Yes	No	Pins / Needles			Venereal		
Cold Limbs	Yes	No	Heart Problem	Yes	No	Feeling in Limbs	Yes	No	Disease	Yes	No
Depression	Yes	No	Hernia	Yes	No	Pneumonia	Yes	No	Visual Problem	Yes	No
Diabetes	Yes	No	Herniated Disc	Yes	No	Polio	Yes	No	Vomiting	Yes	No
Diarrhea	Yes	No	Herpes	Yes	No	Prostate			Other_____		
Digestive			High			Problem	Yes	No	_____		
Problem	Yes	No	Cholesterol	Yes	No	Prosthesis	Yes	No	_____		

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking — Packs / Day_____
- Alcohol — Drinks / Week_____
- Caffeine — Cups / Day_____
- High Stress — Reason_____

Are you pregnant? YES NO Due Date_____

INJURIES / SURGERIES / ACCIDENTS

	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries (Including Cosmetic):		
Automobile Accidents:		

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / SUPPLEMENTS

Balance Natural Medicine LLC

Jason Bojar D.C.
Jessica Balbo D.C.

GENERAL INFORMED CONSENT

I have sought the chiropractic and health care services of Balance Natural Medicine LLC for my personal healthcare, or for my child or children, who are minors. I understand that this chiropractic office uses some diagnostic and treatment methods that are known as complementary, alternative or holistic and may not be covered by my insurance plan, or generally accepted by mainstream medicine. The terms complementary, alternative, and holistic refer to therapies that may include, but are not limited to, dietary and nutritional supplement advice and various diagnostic/testing procedures. Furthermore, the information gained from laboratory and evaluation tests may be interpreted differently from mainstream doctors. Approaches for improving general health and nutrition may be based upon the tests/evaluations and philosophies of complementary medicine and may or may not be consistent with mainstream medical tests/evaluations and philosophies.

In addition to recommending oral nutritional supplements, our office may recommend acupuncture, massage and/or exercise therapies. Some of these products/approaches are not FDA approved or evaluated for any disease or condition, and are not considered the standard practice in mainstream medicine.

Our chiropractic and nutrition practice is exclusively an office-based practice. We are not affiliated with a local hospital. As a result, **WE STRONGLY RECOMMEND THAT IN ADDITION TO OUR CARE YOU MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR HEALTH CONDITIONS.**

For example, in the case of children, we advise that you seek the advice of a pediatrician; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc. Our office routinely refers patients to these and other health care professionals when it is deemed necessary. These physicians can provide you and your family with emergency care if hospitalization is needed, with ongoing follow-up care. We are happy to cooperate and communicate with your doctor(s) regarding your chiropractic condition(s), treatment options, or any other health related issues.

Our office and its employees make no representations, claims, or guarantees regarding the efficacy of our treatment recommendations. The treatments we recommend are based upon a combination of our clinical experience and knowledge of scientific and chiropractic literature. With this information individualized treatments may be offered and applied either as adjunctive (complementary) or primary treatments for various symptoms and disease states.

By signing this informed consent, you agree to hold harmless Balance Natural Medicine LLC including Jason Bojar DC, Jessica Balbo DC and its employees from all professional and personal liability. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. If a legal case is brought against us, you agree that we shall be judged by the standards and principles of complementary, alternative, and/or holistic medicine and not the standards and principles of consensus conventional medicine. You have the right to have this consent reviewed by your lawyer before accepting any chiropractic and/or nutritional services from this office.

Our office makes available nutritional supplements and other health products. You are in no way obligated to purchase these products from our office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish. Balance Natural Medicine LLC and its employees may profit from the sale of supplements and other products that we make available to our patients.

Most insurance plans cover services that they consider medically necessary and/or reasonable and customary. Many of our services (such as nutritional consultations, acupuncture, and others) are often not considered by insurance companies to be necessary based upon their own internal criteria. By signing this form you accept full financial responsibility for all services, including consultations, lab test and other procedures.

SIGNATURE ON FILE: I authorize any holder of medical/chiropractic information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Your signature verifies that you have not been told to discontinue treatments with any other medical specialists or other health care providers.

Your signature is being given prior to rendering any services, advice, and/or recommendations whatsoever from Balance Natural Medicine LLC.

It is the responsibility of the patient to follow-up with our office for results of all testing and lab procedures. It should not be assumed on the part of the patient that if they are not contacted by Balance Natural Medicine, or its employees, or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

The patient is further notified that some tests, or all, may not be covered by their insurance company. The patient assumes full responsibility for the costs of non-covered tests. Balance Natural Medicine LLC does not assume responsibility for costs incurred regarding non-covered and/or potentially covered services, including procedures, lab tests and consultations.

PAYMENT REQUIREMENTS

Our office requires that payment be received for services rendered at the time of your visit. Please come prepared to pay for your visit fees with a check, credit card, or cash. Our office cannot maintain a balance-due for services rendered. If paying by check, please bring more than one check since certain laboratory testing fees require separate payment directly to the laboratory. Some or all of your visit fees may be reimbursable to you by your insurance company. Our front desk will provide you with detailed receipts you will need to submit to your insurance company.

By entering your signature below, you are acknowledging that you understand all terms, verbiage (language), and concepts herein.

I understand this consent agreement and have executed it freely and willingly.

_____ _____

Patient Name (printed) Date

_____

Patient signature

_____

Guardian Name (printed)

_____

Guardian signature