Dr. Timothy Weeks

Backbone of Health

4015 Medina Rd, #90, Medina OH 44256
Western Reserve Professional Bldg on corner of Rt 18 & Foote
330.764-3434

Name____________________________________Date__________

Address____
City__________________________________ Zip Code________
Email____
Home Phone________________________Work_________________
Cell Phone_________________________Fax_________________

Date of Birth____________________________Age_____________
Social Security___________________________Sex______________
Guarantor (if patient is a minor)______________________________

Emergency Contact_____________________________________
Home Phone________________________Cell Phone____________
Marital Status M D S Who referred you to us?_________________

Name of Primary Care Doctor_________________________________
Address____
City, State, Zip code___________________________________
Phone Number____
May we send updates of your progress to your doctor? Yes No

When did you last see a Wellness Physician?________Dr______________
Why did you see this Wellness Physician?__________________________
Were you helped?_________What spinal maintenance program were you given to ensure the future stability of your spine?____________________

____
Did you follow the program? ____ If not, Why?____________________
Why are you changing Wellness Physician?_________________________

Backbone of Health
Consent/Permission to Treat Form

I hereby request and consent to chiropractic treatments including but not limited to chiropractic adjustments, structural manipulation, various muscle and neurological testing, allergy elimination, Bio Electric Stress Testing, acupuncture and other procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by Timothy Weeks D.C., and /or other licensed doctors who now or in the future treat me while employed by, working or associated with or servicing as back-up for Timothy Weeks D.C. and including those personnel working at Backbone of Health or any other office or clinic, whether signatories to this form or not.

I understand that I will be given the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of all chiropractic treatments and procedures before they are performed to me or asked of me. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of standard medicine, in the practice chiropractic there are some risks to treatment, including but not limited to pain, an increase in symptoms or no improvement at all. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I, for myself and my personal representatives, heirs, next of kin, hereby release, waive, discharge and covenant not to sue Backbone of Health, it officers and members, owners and employees from all liability to myself, my personal representatives, assigns, heirs and next of kin for all loss or damage, or any claim or damage therefore, on account of injury of any kid due to the negligence of Backbone of Health, its officers and members, owners and employees.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

I have discussed and understand other treatment options that may be available to me through standard medical approaches and/or other health care providers.

Timothy Weeks D.C. does not offer to diagnose or treat any disease or condition found in the body. We are not here to replace your primary care physician. However, if during the course of an examination, we encounter unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specializes in that area. We may give you information or advice about your present prescriptions, we are in no way recommending you to change or go off of any of your medicine; please advise your primary care physician before making any changes.

Regardless of what the disease in called, we do not offer to treat it. You may be recommended nutrition; this nutrition is not meant to cure or treat any disease but rather to help bring about a state of balance in the body. We do not offer advice regarding treatment prescribed by others. Our only practice objective is to bring balance to the body's systems through chiropractic care so that your body may be better able to treat itself.

Patient Name____

Patient Signature______________________________Date________________

Patient Representate (if necessary)____________________________________

Representative Signature ______________________Date________________

Relationship to Patient____

Backbone of Health
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patent a record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient____________________________________Date________________

Signature____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? ______________ Has another doctor(s) treated you for this condition: ☐Y ☐N

If yes, whom? ______________ Treatment(s): ______________

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: ______________

If this is a recurrence, when was the first time you noticed this problem? ______________

How did it originally occur? ______________ Has it become worse recently? ☐Y ☐N ☐Same ☐Better ☐Gradually worse

How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐Night only How long does it last? ☐All day ☐Few hours ☐Minutes

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Recreation ☐Other: ______________

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐ >10 years

Describe the pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other: ______________

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other: ______________

Is there anything that you can do to relieve the problem? ☐Y ☐N If yes, describe: ______________

If no, what have you tried to do that has not helped? ______________

What do you believe is wrong with you? ______________

Are there any other conditions or symptoms that may be related to your major symptom? ☐Y ☐N If yes, what? ______________

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

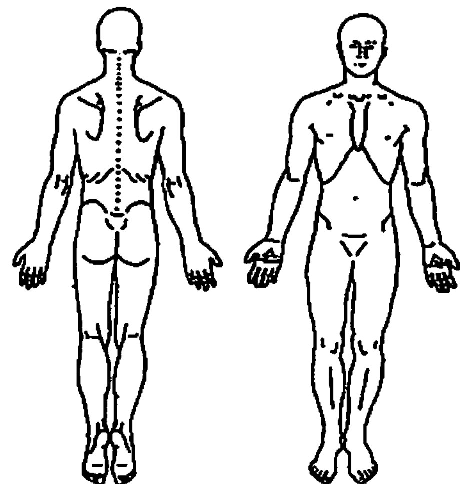
Describe: ______________

Please check all of the symptoms that apply. (P=Past / C= Current)

P / C		P / C		P / C	
☐ ☐	Headache	☐ ☐	High Blood Pressure	☐ ☐	Tingling in Feet
☐ ☐	Facial Pain	☐ ☐	Low Blood Pressure	☐ ☐	Walking Problems
☐ ☐	Eye Pain	☐ ☐	Abdominal Pains	☐ ☐	Sore Muscles
☐ ☐	Blurred Vision	☐ ☐	Nausea/Vomiting	☐ ☐	Weak Muscles
☐ ☐	Dizziness	☐ ☐	Poor Appetite	☐ ☐	Paralysis
☐ ☐	Earache	☐ ☐	Fullness of Bladder	☐ ☐	Shakiness
☐ ☐	Forgetfulness	☐ ☐	Urination Difficulty	☐ ☐	Sweating
☐ ☐	Confusion	☐ ☐	Frequent Urination	☐ ☐	Insomnia
☐ ☐	Sinusitis	☐ ☐	Constipation	☐ ☐	Fainting
☐ ☐	Teeth Grinding	☐ ☐	Hemorrhoids	☐ ☐	Convulsions
☐ ☐	Dry Mouth	☐ ☐	Decreased Sex Drive	☐ ☐	Irritability
☐ ☐	Excessive Thirst	☐ ☐	Menstrual Irregularities	☐ ☐	Impatience
☐ ☐	Unpleasant Taste	☐ ☐	Elbow / Hand Pain	☐ ☐	Fatigue
☐ ☐	Neck Pain	☐ ☐	Tingling in Hands	☐ ☐	Feel Loss of Control
☐ ☐	Sore Throat	☐ ☐	Clammy Hands	☐ ☐	Other: ______
☐ ☐	Lump in Throat	☐ ☐	Low Back Pain		
☐ ☐	Swallowing Pain	☐ ☐	Hip Pain		
☐ ☐	Unsteady Voice	☐ ☐	Knee Pain		
☐ ☐	Shoulder Pain	☐ ☐	Poor Circulation		
☐ ☐	Persistent Coughing	☐ ☐	Swollen Joints		
☐ ☐	Chest Pressure	☐ ☐	Joint Stiffness		
☐ ☐	Slow Heart Rate	☐ ☐	Swollen Ankles		
☐ ☐	Rapid Heart Rate	☐ ☐	Ankle / Foot Pain		

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting - ||| Tingling - :::
Burning - XXX Cramping - ^^^
Numbness - === Dull - ###



ALLERGIES: Please check and list all allergies.

☐ Food: ______

☐ Medications: ______

☐ Seasonal / Other: ______

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had. ______

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? ______

HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda / Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐	______	______

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2
Meals / day	☐	☐	☐	☐

	64+ oz	32-64 oz	16-32 oz	<8 oz
Water / day	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking / Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Detached retina
___Diabetes

___Eczema
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart disease
___HIV / AIDS

___Miscarriage(s)
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic fever
___Stroke

___Tumor(s)
___Ulcer(s)
___Other: ______

______

Patient's Printed Name

______

Patient's Signature

______

Date

Updated 08/08/04

SYMPTOM SURVEY FORM
(Restricted to Professional Use)

PATIENT________________________ AGE______ DOCTOR________________________ DATE__________

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank.**
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 "Lump" in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Cuts heal slowly
8 – 1 2 3 Gag Easily
9 – 1 2 3 Unable to relax, startles easily
10 – 1 2 3 Extremities cold, clammy
11 – 1 2 3 Strong light irritates
12 – 1 2 3 Urine amount reduced
13 – 1 2 3 Heart pounds after retiring
14 – 1 2 3 "Nervous" stomach
15 – 1 2 3 Appetite reduced
16 – 1 2 3 Cold sweats often
17 – 1 2 3 Fever easily raised
18 – 1 2 3 Neuralgia-like pains
19 – 1 2 3 Staring, blinks little
20 – 1 2 3 Sour stomach frequent

GROUP TWO

21 – 1 2 3 Joint stiffness after arising
22 – 1 2 3 Muscle-leg-toe cramps at night
23 – 1 2 3 "Butterfly" stomach, cramps
24 – 1 2 3 Eyes or nose watery
25 – 1 2 3 Eyes blink often
26 – 1 2 3 Eyelids swollen, puffy
27 – 1 2 3 Indigestion soon after meals
28 – 1 2 3 Always seem hungry; feels "lightheaded" often
29 – 1 2 3 Digestion rapid
30 – 1 2 3 Vomiting frequent
31 – 1 2 3 Hoarseness frequent
32 – 1 2 3 Breathing irregular
33 – 1 2 3 Pulse slow; feels "irregular"
34 – 1 2 3 Gagging reflex slow
35 – 1 2 3 Difficulty swallowing
36 – 1 2 3 Constipation, diarrhea alternating
37 – 1 2 3 "Slow starter"
38 – 1 2 3 Get "chilled" infrequently
39 – 1 2 3 Perspire easily
40 – 1 2 3 Circulation poor, sensitive to cold
41 – 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42 – 1 2 3 Eat when nervous
43 – 1 2 3 Excessive appetite
44 – 1 2 3 Hungry between meals
45 – 1 2 3 Irritable before meals
46 – 1 2 3 Get "shaky" if hungry
47 – 1 2 3 Fatigue, eating relieves
48 – 1 2 3 "Lightheaded" if meals delayed
49 – 1 2 3 Heart palpitates if meals missed or delayed
50 – 1 2 3 Afternoon headaches
51 – 1 2 3 Overeating sweets upsets
52 – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
53 – 1 2 3 Crave candy or coffee in afternoons
54 – 1 2 3 Moods of depression - "blues" or melancholy
55 – 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56 – 1 2 3 Hands and feet go to sleep easily, numbness
57 – 1 2 3 Sigh frequently, "air hunger"
58 – 1 2 3 Aware of "breathing heavily"
59 – 1 2 3 High altitude discomfort
60 – 1 2 3 Opens windows in closed room
61 – 1 2 3 Susceptible to colds and fevers
62 – 1 2 3 Afternoon "yawner"
63 – 1 2 3 Get "drowsy" often
64 – 1 2 3 Swollen ankles worse at night
65 – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66 – 1 2 3 Shortness of breath on exertion
67 – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68 – 1 2 3 Bruise easily, "black and blue" spots
69 – 1 2 3 Tendency to anemia
70 – 1 2 3 "Nose bleeds" frequent
71 – 1 2 3 Noises in head, or "ringing in ears"
72 – 1 2 3 Tension under the breastbone, or feeling of "tightness", worse on exertion

SYMPTOM SURVEY FORM - Page 2

GROUP FIVE

- **73** – 1 2 3 Dizziness
- **74** – 1 2 3 Dry skin
- **75** – 1 2 3 Burning feet
- **76** – 1 2 3 Blurred vision
- **77** – 1 2 3 Itching skin and feet
- **78** – 1 2 3 Excessive falling hair
- **79** – 1 2 3 Frequent skin rashes
- **80** – 1 2 3 Bitter, metallic taste in mouth in mornings
- **81** – 1 2 3 Bowel movements painful or difficult
- **82** – 1 2 3 Worrier, feels insecure
- **83** – 1 2 3 Feeling queasy; headache over eyes
- **84** – 1 2 3 Greasy foods upset
- **85** – 1 2 3 Stools light-colored
- **86** – 1 2 3 Skin peels on foot soles
- **87** – 1 2 3 Pain between shoulder blades
- **88** – 1 2 3 Use laxatives
- **89** – 1 2 3 Stools alternate from soft to watery
- **90** – 1 2 3 History of gallbladder attacks or gallstones
- **91** – 1 2 3 Sneezing attacks
- **92** – 1 2 3 Dreaming, nightmare type bad dreams
- **93** – 1 2 3 Bad breath (halitosis)
- **94** – 1 2 3 Milk products cause distress
- **95** – 1 2 3 Sensitive to hot weather
- **96** – 1 2 3 Burning or itching anus
- **97** – 1 2 3 Crave sweets

GROUP SIX

- **98** – 1 2 3 Loss of taste for meat
- **99** – 1 2 3 Lower bowel gas several hours after eating
- **100** – 1 2 3 Burning stomach sensations, eating relieves
- **101** – 1 2 3 Coated tongue
- **102** – 1 2 3 Pass large amounts of foul-smelling gas
- **103** – 1 2 3 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours
- **104** – 1 2 3 Mucous colitis or "irritable bowel"
- **105** – 1 2 3 Gas shortly after eating
- **106** – 1 2 3 Stomach "bloating" after eating

GROUP SEVEN

(A)

- **107** – 1 2 3 Insomnia
- **108** – 1 2 3 Nervousness
- **109** – 1 2 3 Can't gain weight
- **110** – 1 2 3 Intolerance to heat
- **111** – 1 2 3 Highly emotional
- **112** – 1 2 3 Flush easily
- **113** – 1 2 3 Night sweats
- **114** – 1 2 3 Thin, moist skin
- **115** – 1 2 3 Inward trembling
- **116** – 1 2 3 Heart palpitates
- **117** – 1 2 3 Increased appetite without weight gain
- **118** – 1 2 3 Pulse fast at rest
- **119** – 1 2 3 Eyelids and face twitch
- **120** – 1 2 3 Irritable and restless
- **121** – 1 2 3 Can't work under pressure

(B)

- **122** – 1 2 3 Increase in weight
- **123** – 1 2 3 Decrease in appetite
- **124** – 1 2 3 Fatigue easily
- **125** – 1 2 3 Ringing in ears
- **126** – 1 2 3 Sleepy during day
- **127** – 1 2 3 Sensitive to cold
- **128** – 1 2 3 Dry or scaly skin
- **129** – 1 2 3 Constipation
- **130** – 1 2 3 Mental sluggishness
- **131** – 1 2 3 Hair coarse, falls out
- **132** – 1 2 3 Headaches upon arising wear off during day
- **133** – 1 2 3 Slow pulse, below 65
- **134** – 1 2 3 Frequency of urination
- **135** – 1 2 3 Impaired hearing
- **136** – 1 2 3 Reduced initiative

(C)

- **137** – 1 2 3 Failing memory
- **138** – 1 2 3 Low blood pressure
- **139** – 1 2 3 Increased sex drive
- **140** – 1 2 3 Headaches, "splitting or rendering" type
- **141** – 1 2 3 Decreased sugar tolerance

(D)

- **142** – 1 2 3 Abnormal thirst
- **143** – 1 2 3 Bloating of abdomen
- **144** – 1 2 3 Weight gain around hips or waist
- **145** – 1 2 3 Sex drive reduced or lacking
- **146** – 1 2 3 Tendency to ulcers, colitis
- **147** – 1 2 3 Increased sugar tolerance
- **148** – 1 2 3 Women: menstrual disorders
- **149** – 1 2 3 Young girls: lack of menstrual function

(E)

- **150** – 1 2 3 Dizziness
- **151** – 1 2 3 Headaches
- **152** – 1 2 3 Hot flashes
- **153** – 1 2 3 Increased blood pressure
- **154** – 1 2 3 Hair growth on face or body (female)
- **155** – 1 2 3 Sugar in urine (not diabetes)
- **156** – 1 2 3 Masculine tendencies (female)

(F)

- **157** – 1 2 3 Weakness, dizziness
- **158** – 1 2 3 Chronic fatigue
- **159** – 1 2 3 Low blood pressure
- **160** – 1 2 3 Nails, weak, ridged
- **161** – 1 2 3 Tendency to hives
- **162** – 1 2 3 Arthritic tendencies
- **163** – 1 2 3 Perspiration increase
- **164** – 1 2 3 Bowel disorders
- **165** – 1 2 3 Poor circulation
- **166** – 1 2 3 Swollen ankles
- **167** – 1 2 3 Crave salt
- **168** – 1 2 3 Brown spots or bronzing of skin
- **169** – 1 2 3 Allergies - tendency to asthma
- **170** – 1 2 3 Weakness after colds, influenza
- **171** – 1 2 3 Exhaustion - muscular and nervous
- **172** – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Apprehension
174 – 1 2 3 Irritability
175 – 1 2 3 Morbid fears
176 – 1 2 3 Never seems to get well
177 – 1 2 3 Forgetfulness
178 – 1 2 3 Indigestion
179 – 1 2 3 Poor appetite
180 – 1 2 3 Craving for sweets
181 – 1 2 3 Muscular soreness
182 – 1 2 3 Depression; feelings of dread
183 – 1 2 3 Noise sensitivity
184 – 1 2 3 Acoustic hallucinations
185 – 1 2 3 Tendency to cry without reason
186 – 1 2 3 Hair is coarse and/or thinning
187 – 1 2 3 Weakness
188 – 1 2 3 Fatigue
189 – 1 2 3 Skin sensitive to touch
190 – 1 2 3 Tendency toward hives
191 – 1 2 3 Nervousness
192 – 1 2 3 Headache
193 – 1 2 3 Insomnia
194 – 1 2 3 Anxiety
195 – 1 2 3 Anorexia
196 – 1 2 3 Inability to concentrate; confusion
197 – 1 2 3 Frequent stuffy nose; sinus infections
198 – 1 2 3 Allergy to some foods
199 – 1 2 3 Loose joints

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent __________ Standing __________ Pulse __________

Hema-Combistix Urine readings: pH __________ Albumin per cent __________ Glucose per cent __________

Occult Blood __________ pH of Saliva __________ pH of Stool specimen __________ Weight __________

Hemoglobin __________ Blood Clotting Time __________

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row.

MALES
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: __________ Temperature: __________
Date: __________ Temperature: __________
Date: __________ Temperature: __________
Date: __________ Temperature: __________
Date: __________ Temperature: __________
Date: __________ Temperature: __________
Date: __________ Temperature: __________

BP SIT __________ BP STAND __________
PULSE SIT __________ PULSE STAND __________
SALIVA PH __________ BLOOD TYPE __________

CASE RECORD

Name Do not fill out ____________ Date ____________ Telephone ____________

Address ____________ City ____________ State ____________ Zip ____________

Age ____________ Weight ____________ Height ____________ Sex ____________

Occupation ____________ Married ____________

History of Illness and Treatment: ____________

Operations, Accidents or Injuries: ____________

Present Illness or Complaints: ____________

Diagnostic Summary: ____________

Treatment, Recommendations and Progress: ____________

Backbone of Health Clinic
Financial Policy

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE
We request that 100% of the first visit be paid at the time of the visit. A Credit Guarantee form must be filled out and signed*. Future payment may be made time of service unless you are on a payment plan. We are happy to accept your check, Master Card, Visa or Discover. Office visits are $55, excluding tests or x-rays.

GROUP OR INDIVIDUAL INSURANCE
When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance are not a guarantee of payment. A Credit Guarantee form must be filled out and signed*. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays unless you are on a payment plan.

"ON THE JOB" INJURY (Workman's Compensation)
If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees for services are due immediately. A Credit Guarantee form must be filled out and signed*.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS
Please notify your auto insurance carrier of your visit to our office immediately. Notify our Office Manager immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately. A Credit Guarantee form must be filled out and signed*.

MEDICARE
We do NOT accept assignment from Medicare. The check will be sent directly to you in payment of the services that Medicare will cover, which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no cost. A Credit Guarantee must be filled out and signed*.

SECONDARY INSURANCE
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

I understand that my insurance is an arrangement between myself and my insurance company, not between Backbone of Health (BOH) and my insurance company. I request that BOH prepare the customary forms at no charge so that I may obtain insurance benefits.
I understand that I will have a Credit Guarantee on file with Backbone of Health.*
I understand my treatment plan may be cancelled within 30 days with the return of any payment credit. If I suspend or terminate my schedule of care as prescribed by the doctor at BOH after 30 days, fees will be due and payable immediately. I understand that any payment credit I have for services provided that is not used will be forfeited by me** I have read and understand the payment policy of Backbone of Health (BOH)

Name____

Signature______________________________**Date**____________

**Guarantee will not be used without conferring with you*
***Credit will be returned if schedule is terminated because of moving more than 30 miles away or death. Credit returned does not include any discount received.*