# BACK IN MOTION CHIROPRACTIC
## 4007 Old Seward Suite 100 ▪ Anchorage, Alaska 99503 ▪ (907) 562-CARE

# WELCOME!!

### PATIENT INFORMATION

*Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

**(Please Print)**

**Name** _____ **Date** _____
**First** **MI** **Last**

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Sex:** ☐ Female ☐ Male **Birth date:**_____/_____/_____ **SSN** _____-_____-_____

**Home phone** (  ) _____ **Work phone** (  )_____ **Cell phone** (  ) _____

**E-mail:**_____ **Text message:**_____

**Are you:** ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Partnered

**Approximate weight _____ pounds** **Approximate height _____ feet _____ inches**

**Your employer** _____ **Occupation** _____

**Business Address** _____ **City** _____ **State** _____ **Zip**_____

**Emergency Contact** _____ **Emergency phone** (  )_____

**Spouse's Name** _____ **Occupation**_____ **Employer** _____

**Whom may we thank for referring you to us?** _____

### RESPONSIBLE PARTY/INSURANCE INFORMATION

☐ **SELF** ☐ **PARENT/GUARDIAN**

### INSURANCE INFORMATION (Primary coverage) Please provide your insurance card(s)

**Name of Insured** _____ ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT**

**Birth date of policy holder:** _____/_____/_____ **SSN** _____-_____-_____

**Name of employer:** ☐ Same as above_____ **Work phone** (  ) _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Insurance Co.** _____ **Phone** (  ) _____

**Insurance Co. Address** _____ **City** _____ **State** _____ **Zip** _____

**Insurance Identification #**_____ **Group #**_____

### INSURANCE INFORMATION (Secondary coverage) ☐ NONE

**Name of Insured** _____ ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT**

**Birth date of policy holder:** _____/_____/_____ **SSN** _____-_____-_____

**Name of employer:**_____ **Work phone** (  ) _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Insurance Co.** _____ **Phone** (  ) _____

**Insurance Co. Address** _____ **City** _____ **State** _____ **Zip** _____

**Insurance Identification #**_____ **Group #**_____

## CONFIDENTIAL

# INFORMED CONSENT

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures on myself,(or on the patient named below, for whom I am legally responsible) by **Amber D. Mason Riggs, DC** and/or other licensed doctors of chiropractic, who now or in the future, provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic and licensed contractors that are employed by, associated with, or serve as back-up for **Amber D. Mason Riggs, DC** whether or not their names are listed on this form.

I understand and consent to the following procedures: examination, neck and spine/extremity adjustments, joint mobilization, electrical therapies, traction, class IV laser therapy, therapeutic massage, neuromuscular reeducation and or other procedures recommended for my condition(s).

I have had an opportunity to discuss with **Amber D. Mason Riggs** the various types of treatment, including spinal adjustments that have been proposed to me for my condition and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustment s and other chiropractic procedures and understand that there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries and strokes, specifically from neck adjustments. I understand and have had the opportunity to ask about risks and benefits of the proposed treatment and other alternative types of treatment for my condition.

_____ _____

PATIENT NAME – PLEASE PRINT DATE

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____

SIGNATURE IF **OTHER** THAN PATIENT DATE

RELATIONSHIP TO PATIENT: ☐ Mother ☐ Father ☐ Stepmother/father ☐ Legal guardian ☐ _____

**OFFICE/ WITNESS SIGNATURE:_____DATE:_____**

**Back In Motion Chiropractic, LLC**
**4007 Old Seward Highway Ste 100**
**Anchorage, AK 99508**
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**Patient Name (Please print):**_____ **Date:**_____

**The symptom(s) that have prompted me to seek care today include:**_____

_____

_____

**And are the result of:** ☐ Injury – Recreational - Work related - Automobile/Personal Injury (please circle)

☐ Worsening/long term problem ☐ Reoccurrence of previous injury/illness ☐ Other:_____

**Onset** (When did you first notice your CURRENT symptoms?)

_____

**Are your symptoms getting**: ○ Better ○ Worse

**Duration and Timing** (How often do you feel it?)

○ Constant ○ Comes and goes

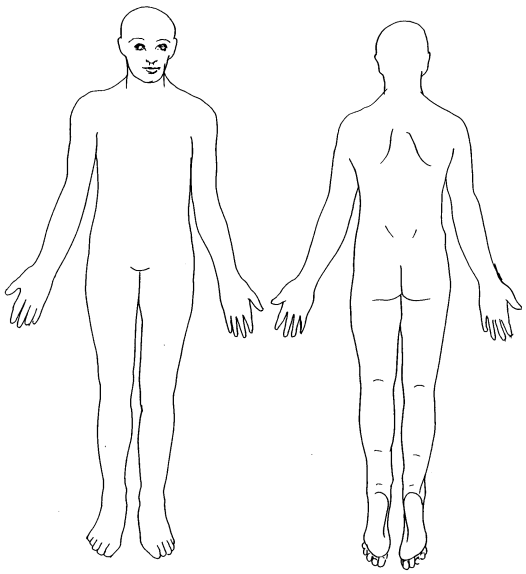
How often (times per day/week)? _____

**Intensity** (How extreme are your symptoms?) Please circle: **0 1 2 3 4 5 6 7 8 9 10**

**Quality of Symptoms**
(What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Stabbing
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Sharp
- ○ Aching
- ○ Dull
- ○ Pinching
- ○ Boring
- ○ Soreness
- ○ Weakness
- ○ Tender
- ○ Deep
- ○ Superficial

**Location** (Where does it hurt?)
Indicate the area(s) on the drawing.



**Radiating pain** (Does it affect other areas of your body? Where does it radiate, shoot or travel?)_____

_____

**Aggravating or Relieving Factors** (What makes it better or worse):

| Better | Worse | |
|---|---|---|
| ☐ | ☐ | Morning |
| ☐ | ☐ | Afternoon |
| ☐ | ☐ | During sleep hours |
| ☐ | ☐ | Standing from sitting |
| ☐ | ☐ | Bending |
| ☐ | ☐ | Lying down flat |
| ☐ | ☐ | Sitting |
| ☐ | ☐ | Exercise/Stretching |
| ☐ | ☐ | Walking |
| ☐ | ☐ | Standing |
| ☐ | ☐ | Desk/Computer work |
| ☐ | ☐ | Medication:_____ |
| ☐ | ☐ | Other:_____ |

## Dr's Notes:

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**Patient Name (Please print):**_____ **Date:**_____

## REVIEW OF SYSTEMS

### MUSCULOSKELETAL

| Had | Have | |
|---|---|---|
| ○ | ○ | Osteoporosis |
| ○ | ○ | Arthritis |
| ○ | ○ | Scoliosis |
| ○ | ○ | Neck Pain |
| ○ | ○ | Back Problems |
| ○ | ○ | Hip disorders |
| ○ | ○ | Knee injuries |
| ○ | ○ | Foot/Ankle pain |
| ○ | ○ | Shoulder problems |
| ○ | ○ | Elbow/wrist pain |
| ○ | ○ | TMJ issues |
| ○ | ○ | Poor posture |
| ○ | ○ | Other_____ |

_____

_____

### NEUROLOGICAL

| Had | Have | |
|---|---|---|
| ○ | ○ | Anxiety |
| ○ | ○ | Depression |
| ○ | ○ | Headache |
| ○ | ○ | Dizziness |
| ○ | ○ | Pins and needles |
| ○ | ○ | Numbness |
| ○ | ○ | Tingling |
| ○ | ○ | Migraine |

### CARDIOVASCULAR

| Had | Have | |
|---|---|---|
| ○ | ○ | High blood pressure |
| ○ | ○ | Low blood pressure |
| ○ | ○ | High cholesterol |
| ○ | ○ | Poor circulation |
| ○ | ○ | Angina |
| ○ | ○ | Excessive bruising |

### RESPIRATORY

| Had | Have | |
|---|---|---|
| ○ | ○ | Asthma |
| ○ | ○ | Apnea |
| ○ | ○ | Emphysema |
| ○ | ○ | Hay fever |
| ○ | ○ | Shortness of breath |
| ○ | ○ | Pneumonia |

### DIGESTIVE

| Had | Have | |
|---|---|---|
| ○ | ○ | Anorexia / Bulimia |
| ○ | ○ | Ulcer |
| ○ | ○ | Food Sensitivities |
| ○ | ○ | Heartburn / Acid reflux |
| ○ | ○ | Constipation |
| ○ | ○ | Diarrhea |

### SENSORY

| Had | Have | |
|---|---|---|
| ○ | ○ | Blurred vision |
| ○ | ○ | Ringing in ears |
| ○ | ○ | Hearing loss |
| ○ | ○ | Chronic ear infection |
| ○ | ○ | Loss of smell |
| ○ | ○ | Loss of taste |
| ○ | ○ | Hearing aids |
| ○ | ○ | Corrective lenses / Contact lenses |

### ENDOCRINE

| Had | Have | |
|---|---|---|
| ○ | ○ | Thyroid issues |
| ○ | ○ | Immune disorders |
| ○ | ○ | Hypoglycemia |
| ○ | ○ | Frequent infections |
| ○ | ○ | Swollen glands |
| ○ | ○ | Low energy |

### INTEGUMENTARY (SKIN)

| Had | Have | |
|---|---|---|
| ○ | ○ | Skin cancer |
| ○ | ○ | Psoriasis |
| ○ | ○ | Eczema |
| ○ | ○ | Acne |
| ○ | ○ | Skin sensitivities |
| ○ | ○ | Rash |
| ○ | ○ | Edema / Swelling |

**Dr's Notes:**_____

_____

_____

_____

_____

_____

_____

_____

### GENITOURINARY

| Had | Have | |
|---|---|---|
| ○ | ○ | Kidney stones |
| ○ | ○ | Infertility |
| ○ | ○ | Prostate issues |
| ○ | ○ | PMS symptoms |

### CONSTITUTIONAL

| Had | Have | |
|---|---|---|
| ○ | ○ | Fainting |
| ○ | ○ | Poor appetite |
| ○ | ○ | Fatigue |
| ○ | ○ | Sudden weight gain /loss (circle one) |
| ○ | ○ | Weakness |

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**Patient Name (Please print):**_____ **Date:**_____

**ILLNESS** (Check the illnesses you have **Had** in the past or **Have** now.)

| Had | Have | |
|---|---|---|
| ○ | ○ | AIDS |
| ○ | ○ | Alcoholism |
| ○ | ○ | Allergies |
| ○ | ○ | Arteriosclerosis |
| ○ | ○ | Cancer |
| ○ | ○ | Chicken pox |
| ○ | ○ | Diabetes |
| ○ | ○ | Epilepsy |
| ○ | ○ | Glaucoma |
| ○ | ○ | Goiter |
| ○ | ○ | Gout |
| ○ | ○ | Heart disease |
| ○ | ○ | Hepatitis |
| ○ | ○ | HIV positive |
| ○ | ○ | Malaria |
| ○ | ○ | Measles |
| ○ | ○ | Multiple Sclerosis |
| ○ | ○ | Mumps |
| ○ | ○ | Polio |
| ○ | ○ | Rheumatic fever |
| ○ | ○ | Scarlet fever |
| ○ | ○ | Sexually transmitted disease |
| ○ | ○ | Stroke |
| ○ | ○ | Tuberculosis |
| ○ | ○ | Typhoid fever |
| ○ | ○ | Ulcer |
| ○ | ○ | Other:_____ |

**TREATMENTS** (Check the ones you've received in **Past** or are receiving **Currently)**

| Past | Current | |
|---|---|---|
| ○ | ○ | Acupuncture |
| ○ | ○ | Antibiotics |
| ○ | ○ | Blood transfusions |
| ○ | ○ | C Pap or Bi-Pap machine |
| ○ | ○ | Chemotherapy |
| ○ | ○ | Chiropractic care |
| ○ | ○ | Cortisone injections |
| ○ | ○ | Dialysis |
| ○ | ○ | Epidural injections |
| ○ | ○ | Homeopathy / Naturopathic care |
| ○ | ○ | Hormone replacement |
| ○ | ○ | Inhaler |
| ○ | ○ | Massage therapy |
| ○ | ○ | Physical therapy |
| ○ | ○ | Other:_____ |

**NUTRITIONAL SUPPLEMENTS / VITAMINS / HERBS**

Please list ALL that you are currently taking:_____

_____

_____

**MEDICATIONS** Please list ALL current prescription & over the counter that you are currently taking:_____

_____

_____

**ALLERGIES** Please list ALL allergies: _____

_____

## Dr's Notes

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**Patient Name (Please print):**_____ **Date:**_____

## HISTORY OF INJURY/ FRACTURES/ SURGERIES

**PLEASE ENTER YEAR OF INJURY/SURGERY: (example – 1987) and CLICK R (right) or L (left) if indicated**

**PREVIOUS INJURIES:** ☐ I have no history of previous painful injury. _____(patient's initial's)

Work Injury_____ Car/Motorcycle Accident_____ Sports Injury_____

Head Injury_____ Headaches/Migraines_____ Other_____

**FRACTURES/BROKEN BONES:** ☐ I have no history of fractures/broken bones. _____ (patient's initials)

Arm/wrist/ hand_____ ☐ R ☐ L Collar (clavicle)_____ ☐ R ☐ L Hip/pelvis_____ ☐ R ☐ L

Leg/knee/foot_____ ☐ R ☐ L Nose/facial_____ Spinal Vertebrae_____

Ribs_____ Other: _____

**PREVIOUS SURGERIES:** ☐ I have no history of previous surgeries. _____ (patient's initial's)

Appendix_____ Gallbladder_____ Eye_____ ☐ R ☐ L Ear_____ ☐ R ☐ L

Head/Brain_____ Heart_____ Hernia: ☐ hiatal / ☐ inguinal _____

Disc/Spine: Neck_____ Back_____ Pelvis_____ Spinal Cord/Nerve_____

Leg/knee/hip_____☐ R ☐ L Shoulder_____ ☐ R ☐ L Collar bone (clavicle)_____ ☐ R ☐ L

Arm/wrist/ hand_____ ☐ R ☐ L Tonsillectomy_____ Wisdom teeth_____

Hysterectomy – complete_____ uterus only_____ Cosmetic_____

Breast Implants_____ Vasectomy_____ Other_____

Cancer_____ Please list what type and treatment:_____

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## Dr's Notes

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**Patient Name (Please print):**_____ **Date:**_____

**FAMILY HISTORY**

| Relative | Age if living | State of health good | poor | Illnesses | Age at time of death | Cause of death illness | natural |
|---|---|---|---|---|---|---|---|
| Mother | _____ | O | O | _____ | _____ | O | O |
| Father | _____ | O | O | _____ | _____ | O | O |
| Sister 1 | _____ | O | O | _____ | _____ | O | O |
| Sister 2 | _____ | O | O | _____ | _____ | O | O |
| Brother 1 | _____ | O | O | _____ | _____ | O | O |
| Brother 2 | _____ | O | O | _____ | _____ | O | O |
| _____ | _____ | O | O | _____ | _____ | O | O |
| _____ | _____ | O | O | _____ | _____ | O | O |

Are there any hereditary health issues that you know about ?_____

_____

**SOCIAL HISTORY** (Tell us about your health habits and stress level)

**Alcohol use** O Never O Daily O Weekly How much? _____ O Beer O Wine O Liquor

**Coffee use** O Never O Daily O Weekly How much? _____

**Soft drinks** O Never O Daily O Weekly How much? _____

**Water intake** O Never O Daily O Weekly How much? _____

**Tobacco use** O Never O Daily O Weekly How much? _____ O Quit _____ When _____
O Pipe O Cigar O Chew O Cigarettes

**Recreational Drugs** O Never O Daily O Weekly How much? _____ O Quit _____ When _____

**Exercise** O Never O Daily O Weekly How much?_____ What type:_____

_____

## Dr's Notes

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**Patient Name (Please print):**_____ **Date:**_____

## ACTIVITIES OF DAILY LIVING

**How does this condition currently interfere with your life and ability to function:**

| | No effect | Mild effect | Moderate effect | Severe effect | | | No effect | Mild effect | Moderate effect | Severe effect |
|---|---|---|---|---|---|---|---|---|---|---|
| Sitting | | | | | | Grocery shopping | | | | |
| Rising out of chair | | | | | | Household chores | | | | |
| Standing | | | | | | Lifting objects | | | | |
| Walking | | | | | | Reaching overhead | | | | |
| Lying down | | | | | | Showering/bathing | | | | |
| Bending over | | | | | | Dressing myself | | | | |
| Climbing stairs | | | | | | Love life | | | | |
| Using a computer | | | | | | Getting to sleep | | | | |
| Getting in/out of car | | | | | | Staying asleep | | | | |
| Driving a car | | | | | | Concentrating | | | | |
| Looking over shoulder | | | | | | Exercising | | | | |
| Caring for family | | | | | | Yard work | | | | |

**Does your current condition interfere with your:**

- Work or career? ☐ Y ☐ N In what way? _____
- Recreational activities? ☐ Y ☐ N In what way? _____
- Household responsibilities? ☐ Y ☐ N In what way? _____
- Personal relationships? ☐ Y ☐ N In what way? _____

**How much sleep do you average per night?** _____ Hours

- Preferred sleep position: ☐ Back ☐ Stomach ☐ Side lying
- Do you awake feeling rested? ☐ Y ☐ N
- Is your sleep disrupted due to current condition? ☐ Y ☐ N

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## CLINIC POLICIES

1. Payment is due at the time of service. All insurance co-pays and deductibles will be collected at the time of service. A service charge of $5.00 will be added to your account for co-pays not paid at the time of service.

2. Patients are responsible for providing current insurance coverage/billing information at the time of service. Our office will bill your primary insurance as a courtesy only. Insurance policy benefits and restrictions are between a patient and their insurance company. Secondary insurance coverage may be billed if agreed upon in advance by Back In Motion Chiropractic, LLC. At any time my insurance company may request a copy of my medical records. If upon review of those records, they find my treatment to be not medically necessary, I may be responsible for those charges.

3. It is the patient or guarantor's responsibility to keep his/her account balance with Back In Motion Chiropractic, LLC current. Account balances must be paid in full within ninety (90) days of the date of service. Checks, Cash, Visa and MasterCard are accepted. Accounts with an outstanding balance after that time may be sent to Cornerstone Collection Agency. All fees charged by Cornerstone Collection Agency will be the responsibility of the patient or guarantor of the account.

4. A fee of $15.00 will be charged each month to all accounts not paid in full.

5. If your care is being paid for by a worker's compensation claim you are still personally responsible for the bills in the event coverage is controverted, cancelled, or treatment is discontinued against doctor's recommendations.

6. Personal Injury claims are billed as a courtesy. A claim number, billing address, phone number and amount of med-pay benefit payments available on your policy are required and must be provided within 48 hours of the initial visit for the injury. Charges will be submitted to insurance provided once. Payment for all services is due within ninety (90) days of the date of service regardless of the status of your claim. Additional billing to auto insurance or other insurance companies will be the responsibility of the patient. Back In Motion Chiropractic does not participate in third party claims and do not wait for final settlement of claims for payment. (A separate clinic policy will be signed for Personal Injury Claims.)

7. We reserve the right to bill the patient for missed appointments unless notified within 24 hours of the need to reschedule. The charge for a missed appointment is $50.00. This charge will be collected from the patient before another appointment is scheduled.

I hereby authorize my healthcare provider to render whatever services are necessary for the care of me and/or my family and I agree to assume all financial obligations incurred for such care. I hereby authorize release of information to insurance carriers concerning my illness and treatments and I also hereby assign to the physician(s) payments for medical services rendered to myself and my dependents.

Signature:_____ Date:_____

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## HIPAA ACCEPTANCE FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and its enacting regulations found at 45 CFR Part 164 et seq. (the "Security Rule", the "Breach Notification Rule" and the "Privacy Rule") as well as the Alaska Personal Information Protection Act found at AS 45.48., . I have certain rights to privacy regarding my protected health information. I understand the information can be and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and accreditation.

I have been informed by a representative of Back In Motion Chiropractic of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of the organizations Notice of Privacy Practices _____ (initial) **or** the opportunity to review such Notice of Privacy Practices _____ (initial) prior to signing this consent. I understand the organizations have the right to change its Notice of Privacy Practices from time to time and I may contact the organizations at any time at the address above to request a current copy of the Notice of Privacy Practices.

I understand I may request in writing you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____
(patients name – please print)

_____ _____
(patients signature) (date)

_____ _____
(parent/guardian if patient is a minor) (date)

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# PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Back In Motion Chiropractic, LLC to use and/or disclose Protected Health Information (PHI) about me to:

- Please list the name of authorized individuals below

_____

_____

This authorization permits Back In Motion Chiropractic, LLC and to use and/or disclose the following PHI about me:

☐ All Protected Health Information

☐ Dates of Service ☐ Account/Billing/Payment Information

☐ Insurance Information ☐ Medical/Treatment Information

☐ Please list specific information that may be disclosed:_____

_____

This authorization will expire one year from today's date. I have the right to revoke this authorization in writing except to the extent that the practices have acted in reliance upon this authorization. My revocation must be submitted in writing.

Back In Motion Chiropractic, LLC may contact and/or leave a message for me at the following numbers(s):

- Please list the number(s) that you wish to be contacted at in the order that you prefer us to contact you.

| | | Type of Message | |
|---|---|---|---|
| 1._____ | ☐ cell ☐ wk ☐ home | ☐ General | ☐ Detailed/Confidential |
| 2._____ | ☐ cell ☐ wk ☐ home | ☐ General | ☐ Detailed/Confidential |
| 3._____ | ☐ cell ☐ wk ☐ home | ☐ General | ☐ Detailed/Confidential |

Patient Name (please print):_____ Date:_____

Signature of Patient or Legal Guardian:_____