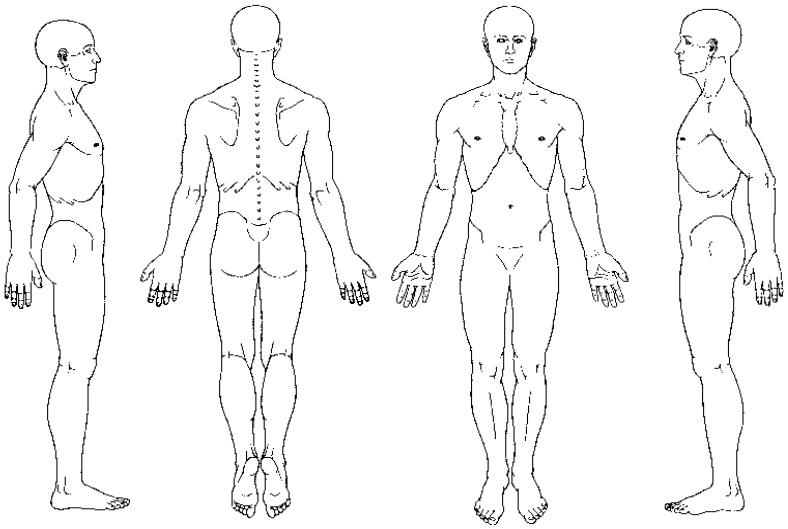
Back to Health
Family Chiropractic
CARE FOR A BETTER LIFE

Dr. CHRIS MICHLIN, D.C., B.C.A.O.
NANCY MICHLIN, M.ED., C.H.C.
6324 CAMP BOWIE BOULEVARD
FORT WORTH, TEXAS 76116
817.810.9111

Personal History

Name: _____ Date:_____
Complete Address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Social Security #: _____ Birth Date: _____ Age: _____
Assigned Gender (circle one): **M F Intersex** Gender Identity/Expression: _____
Driver's License Number: _____ Licensing State: _____
Email Address: _____
Circle One: Single Relationship Engaged Married Domestic Partnership Separated Divorced Widowed
Name of Partner: _____ Partner's Phone Number: _____
Name and Number of Emergency Contact: _____
Name and Ages of Children: _____
Employer: _____
Type of Work: _____
Referred to this Office By: _____
Who Is Financially Responsible For Treatment: ___Self ___Partner ___Medicare ___Auto Insurance (PIP)
Insurance: _____ Member ID #:_____
Insured Person's Name: _____ Birth Date: _____
Insured Person's Social Security Number: _____

Comprehensive Health History



Please indicate on the diagram the area of your discomfort.

AAA = Ache
/// = Sharp/Stabbing
BBB = Burning
DDD = Dull
TTT = Pins & Needles
OOO = Other

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History of Present Illness:

Location of Symptoms (Where does it hurt?)

_____
_____
_____

Mechanism of Trauma (How did it happen?)

_____
_____
_____

Onset (When did it start?)

_____
_____
_____

Quality/Character of the symptom(s) (check all that apply)

- O Sharp
- O Dull
- O Ache
- O Stabbing
- O Burning
- O Throbbing
- O Numbness
- O Pins and Needles
- O Spasm
- O Swelling
- O Stiffness
- O Other, Please describe:

_____
_____
_____
_____
_____
_____
_____

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Frequency/Duration (When and how long do the symptoms last?):

_____
_____
_____
_____

On a Scale of 1 to 10, with 1 being the best and 10 being the worst, list and rate the severity of your symptoms:

- Symptom:_____Severity: 1 2 3 4 5 6 7 8 9 10
- Symptom:_____Severity: 1 2 3 4 5 6 7 8 9 10
- Symptom:_____Severity: 1 2 3 4 5 6 7 8 9 10

What makes it feel worse?

_____
_____
_____
_____

What makes it feel better?

_____
_____
_____

Have you ever experienced these symptoms before? (If yes, please explain)

_____
_____
_____

Please list all secondary complaints (i.e. headaches, numbness)

_____
_____
_____

What previous care have you had for this condition?

_____
_____
_____

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Do you have any of the following conditions?

- O Increased joint mobility (i.e. loose joints)
- O Significant bone loss (i.e. osteoporosis)
- O Benign bone tumors (i.e. non-cancerous)
- O Bleeding disorders
- O Take blood thinners
- O Weakness/Loss of control of your bladder, bowels or muscles

(The above conditions may rule out the use of adjustment due to risk of injury. The doctor will discuss this with you before treatment.)

O **By initialing here, you consent to treatment using spinal adjustments.** _____

Do you have any of the following conditions?

- O Inflammatory joint disease
- O Ankylosing spondylitis
- O Ligament laxity
- O Joint dislocation
- O Recent/unstable joints
- O Unstable/missing dens at C2
- O Spinal cancer
- O Spinal/joint infection
- O Myelopathy/cauda equine syndrome
- O Vertebrobasilar insufficiency syndrome
- O Arterial aneurysm

(If you currently have, or have had, one of the above listed conditions, spinal adjustment will not be performed to the affected area.)

O **By initialing here, you acknowledge this notice and agree to inform this office if another health care provider tells you that you have one of these conditions.** _____

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Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

- O Pneumonia
- O Rheumatic Fever
- O Polio
- O Tuberculosis
- O Whooping Cough
- O Anemia
- O Measles
- O Mumps
- O Small Pox
- O Chicken Pox
- O Diabetes
- O Cancer
- O Heart Disease
- O Thyroid
- O Influenza (Flu)
- O Pleurisy
- O Arthritis
- O Epilepsy
- O Mental Disorders
- O Lumbago
- O Eczema

Intake:

- O Coffee
- O Tea
- O Alcohol
- O Cigarettes
- O White Sugar

Have you ever been tested HIV Positive? ___Yes ___No

Check any of the following you have had in the past 6 months:

Muscolo-Skeletal Code

- O Low Back Pain
- O Pain Between Shoulders
- O Neck Pain
- O Arm Pain
- O Joint Pain/Stiffness
- O Walking Problems
- O Difficult Chewing/Clicking Jaw
- O General Stiffness

Nervous System Code

- O Nervous
- O Numbness
- O Paralysis
- O Dizziness
- O Forgetfulness
- O Confusion/Depression
- O Fainting
- O Convulsions
- O Cold/Tingling Extremities
- O Stress

General Code

- O Fatigue
- O Allergies
- O Loss of Sleep
- O Fever
- O Headaches

Gastro-Intestinal Code

- O Poor/Excessive Appetite
- O Excessive Thirst
- O Frequent Nausea
- O Vomiting
- O Diarrhea
- O Constipation
- O Hemorrhoids
- O Liver Problems
- O Gall Bladder Problems
- O Weight Trouble
- O Abdominal Cramps
- O Gas/Bloating After Meals
- O Heartburn
- O Black/Bloody Stool
- O Colitis

Genito-Urinary Code

- O Bladder Trouble
- O Painful/Excessive Urination
- O Discolored Urine

C-V-R Code

- O Chest Pain
- O Short Breath
- O Blood Pressure Problems
- O Irregular Heartbeat
- O Heart Problems
- O Lung Problems/Congestion
- O Varicose Veins
- O Ankle Swelling
- O Stroke

EENT Code

- O Vision Problems
- O Dental Problems
- O Sore Throat
- O Ear Aches
- O Hearing Difficulty
- O Stuffed Nose

Male/Female Code

- O Menstrual Irregularity
- O Menstrual Cramps
- O Vaginal Pain/Infection
- O Breast Pain/Lumps
- O Prostate/Sexual Dysfunction
- O Other Problems
- O _____
- O _____

Females:

When was your last period?

_____

Are you pregnant?

___Yes ___No

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Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Chicken Pox
- ☐ Cold/Tingling extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain/Difficulties
- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Heart Problems
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Jaw Clicking/Stiffness
- ☐ Joint Pain/Stiffness
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Lung Problems/Congestion
- ☐ Low Back Pain
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Pain Between Your Shoulders
- ☐ Paralysis
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems/insomnia
- ☐ Spinal Curvatures
- ☐ Stress
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Pain/Infection
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

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If you checked any of the above symptoms, please explain here:

Please list all medications that you are currently taking:

Please list all vitamins and/or nutritional supplements that you are currently taking:

Past History

Spinal Injuries:

Surgeries (please include dates of surgeries):

Hospitalizations:

Last Physical Examination: _____

Previous Chiropractic Care:

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Family History

Has anyone in your family had the same or a similar problem as you are having now?

- o Yes
- o No

If so, please list their relationship to you (father, mother, brother, sister, grandmother, grandfather, etc.)

_____
_____
_____

Has anyone in your family had any of the following?

- o Heart Disease
- o Diabetes
- o Cancer Type: _____
- o Spinal Problems

If so, please list their relationship to you (father, mother, brother, sister, grandmother, grandfather, etc.)

_____
_____
_____

Social History

Smoking History

- o Current every day smoker
  Packs/day: _____
- o Current some day smoker
  Pack/Week: _____
- o Former smoker
  Start Date: _____
  Quit Date: _____
  Pack/Day: _____
- o Never smoked

Do you consume alcoholic beverages?

- o Yes - How much? _____
- o No

How often do you exercise/active?

- o Daily
- o Weekly
- o Infrequently
- o Never

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Most patients who come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing it.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

- O Relief Care
- O Corrective Care
- O Check here if you want the Doctor to select the type of care appropriate for your condition.

Patient's Signature: _____ Date: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Back To Health Family Chiropractic, LLC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Back To Health Family Chiropractic, LLC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's
Signature of Authorizing Care: _____ Date: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or 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 another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

I understand I can speak with the chiropractor regarding the doctor's objective pertaining to my care in this office. Therefore, I accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) (Date)

ALL FEMALES - Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: _____

_____ _____
(Signature) (Date)

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E-Mail Authorization

I would like to share my e-mail address with Back To Health Family Chiropractic for the following uses:

- Contact me regarding schedule changes
- Re-schedule missed appointments
- Inform me of upcoming events in the clinic which may affect me
- Send me a monthly newsletter
- Provide special offers that are available to patients

My e-mail address as with any of my private information is not to be used or shared in any manner that is prohibited by HIPPA laws or inconsistent with the Notice of Privacy Practices which has been made available to me by Back To Health Family Chiropractic.

_____
Patient Name

_____
E-mail Address

_____ _____
(Signature) (Date)

Voice Mail Authorization

I authorize Back To Health Family Chiropractic the ability to leave detailed voice mail messages regarding my treatment and appointments at the following phone numbers:

_____
Mobile Phone

_____
Home Phone

_____ _____
(Signature) (Date)

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INSURANCE STATEMENT

Our clinic does not accept insurance payment for services.

If you have insurance that covers chiropractic, you will be able to submit claims and get reimbursed. The insurance company will send the check directly to you.

Here's how:

Submitting claims to your insurance company is typically a simple procedure.

1. If you plan on filing a claim to be reimbursed by your insurance, let us know. At the end of the week we will print out your receipt which has the information that your insurance company needs.

2. Contact your insurance company to obtain the form you need to fill out. This is separate from the receipt that you will receive from the clinic.

3. Fill in the form from the insurance company. Make copies of this form as well as your receipts to keep for your records.

4. Mail the form and receipt to the address the insurance company gives you.

If you have any questions, please feel free to ask us at any time. We will help you as much as we can.

Patient Signature: _____ Date: _____

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Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Back To Health Family Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

List Others to Whom We May Release Your PHI (Family, Health Practitioners, Attorneys, etc.)

_____

_____

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it. I am aware this office DOES have an open consult area; and if at any time, I desire privacy, I may request a private room.

_____
Name of Patient (print)

_____
Signature of Patient **Date**

_____
Signature of Patient Representative **Date**

_____
Relationship of Patient Representative to Patient

_____
Office Representative **Date**

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ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Back To Health Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Back To Health Family Chiropractic's Notice of Privacy Practices prior to signing this document. Back To Health Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Back To Health Family Chiropractic. The Notice of Privacy Practices for Back To Health Family Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and Back To Health Family Chiropractic's duties with respect to my protected health information.

Back To Health Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for on at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Name of Privacy Officer: Nancy L. Baskin Michlin, M.Ed.

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NOTICE OF APPOINTMENT CANCELLATION/NO-SHOW POLICY

We understand extenuating circumstances may prevent you from being present at your appointment. At the same time, increasing numbers of missed appointments are negatively impacting our ability to provide excellent care to our patients.

We would like to inform you of our policy regarding missed appointments and same-day cancellations. Any patient who misses a scheduled appointment without notifying the office at least 24 hours in advance will be subject to a no-show fee.

We reserve the right to charge you (not your insurance company) for a missed appointment. A fee of $85 for a missed appointment will be assessed. At this time, patients who provide a 24 hour advanced notice for cancelled appointments will not be assessed a fee.

If you have any questions regarding this policy please do not hesitate to contact our office at 817-810-9111. It is our hope that this policy will reduce wait times and increase efficiency at our office so that we may better serve you with safe and quality chiropractic and wellness care.

Please sign and date below:

Signature: _____ Date: _____

Name Printed: _____

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Referral Source

Patient Name: _____ Date: _____

Dear New Patient:

We are happy you found us! We are interested in tracking our referral and marketing sources so we can help more people achieve great health and wellness. Please complete this form to help us in our efforts.

Thank you so much!
Dr. Chris & Nancy Michlin

How did you hear about our practice?
(Please check all that apply and be as specific as possible.)

- ☐ Another Health Care Provider. Please Provide a Name: _____
- ☐ Friend/Family/Word of Mouth. Please Provide a Name: _____
- ☐ Google Search. Search Terms Used: _____
- ☐ Yahoo Search. Search Terms Used: _____
- ☐ Bing Search. Search Terms Used: _____
- ☐ Other Search Engine. Name/Terms Used: _____
- ☐ Atlas Orthogonal Website: _____
- ☐ Attorney. Please Provide a Name: _____
- ☐ Event: _____
- ☐ Magazine: _____
- ☐ Phonebook: _____
- ☐ Our Printed Material. Which one? _____
- ☐ Other Advertisement. Where? _____
- ☐ Location/Walk In
- ☐ Other: _____