Balanced Health Chiropractic Center of West Michigan, PLC

300 S State St, Ste 4, Zeeland MI 49464
Ph. 616-772-9255 / Fx. 616-772-9258

Patient Information

Last Name	First	MI	Patient date of birth	Social Security Number

Patient Address	City	State	Zip Code

Home Number	Cell Number	Email	Spouse / Guardian

Work Number	Employer	How did you hear about us? (If from a current patient, please list name)

Physicians Name and Number	Dentists Name and Number

Describe any operations you've had and the dates: _____

Have you been treated by a physician for any health condition in the last year? □ Yes □ No

Condition: _____ Date of last physical: _____

Are you now taking any Medications? Yes No If yes, please list: _____

Are you pregnant or nursing? Yes No Date of last menstrual cycle: _____

Primary Insurance Information

Insurance ID	Group Number		Subscriber Date of Birth	Subscribers SSN

Subscribers Last Name	First	MI	Blue Care Network Referral #

Secondary Insurance Information (If applicable)

Insurance ID	Group Number		Subscriber Date of Birth	Subscribers SSN

Subscribers Last Name	First	MI	Blue Care Network Referral #

Is this injury related to an Auto or Work Accident? Auto □ Work □ None □

I authorize Balanced Health Chiropractic Center to release information to _____ (Insurance Company) in order to obtain reimbursement for my care. Initials: _____

I authorize _____ (Insurance Company) to pay Balanced Health Chiropractic Center directly. Initials: _____

I understand I am financially responsible for any balance not paid by my insurance. Initials: _____

Nature of Condition: Initial onset within last 3 months Multiple episodes Continuous

Date symptoms began on: _____

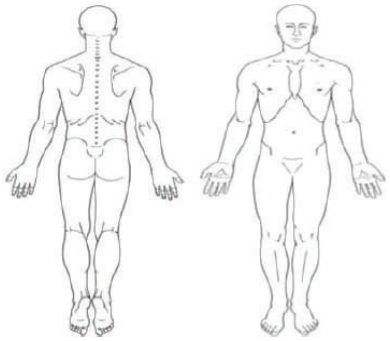
1. Briefly describe current symptoms: _____

2. How did each of the symptoms start? _____

3. Average pain or discomfort intensity: (Circle one)

	None at all										worst pain (discomfort)
Last 24 hours:	0	1	2	3	4	5	6	7	8	9	10
Past week:	0	1	2	3	4	5	6	7	8	9	10

Indicate where you have pain or other symptoms



4. How often do you experience your symptoms?

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

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

6. How is your condition changing, since care began at this facility?

□ **N/A - This is the initial visit** □ Much worse □ Worse □ A little worse □ No change □ A little better □ Better □ Much better

7. In general, would you say your overall health right now is…

□ Excellent □ Very good □ Good □ Fair □ Poor

Patient Signature: _____ Date: _____