Patient #_____
(for office use only)

Bountiful Life Chiropractic Center

1310 SW State St Ste B, Ankeny, IA, 50023 Phone: 515-965-8280

Ages 6 to Adult

Personal and Confidential Information **Today's Date:**

First Name:	Middle Initial:	Nickname:
Last Name:		
Guardian's Name (*if aged 6-17*)	First Name:	Last Name:

DOB:	Age:	SSN:	Gender: **M** or **F**
Cell #: ( )	Cell phone provider: (ex: Verizon, AT&T, Sprint - for text reminders)		Home #: ( )
Marital Status: **S M W D**	Spouses Name (if applicable)		

Address:	City/State:	Zip:
Email:	Do you want email reminders in addition to text reminders? **Y** or **N**	
Medicaid? *If so, please provide card*		

Preferred method of communication: 0 Email 0 Phone 0 Text	How did you find out about our office?	If referred, by whom?

Personal Medical History: *circle Ⓝ for **Now** and/or Ⓟ for **Past***

Now or **P**ast Allergies	**N** or **P** Constipation	**N** or **P** Irreg Heart Beat	**N** or **P** Prostate Trouble
Now or **P**ast Alcoholism	**N** or **P** Cramps	**N** or **P** Headache	**N** or **P** Sciatica
Now or **P**ast Anemia	**N** or **P** Depression	**N** or **P** Hot Flashes	**N** or **P** Short of Breath
Now or **P**ast Arteriosclerosis	**N** or **P** Diabetes (type 1 or 2)	**N** or **P** Kidney Infection	**N** or **P** Sinus Infection
Now or **P**ast Arthritis	**N** or **P** Digestion Trouble	**N** or **P** Kidney Stones	**N** or **P** Spinal Curvatures
Now or **P**ast Asthma	**N** or **P** Dizziness	**N** or **P** Loss of Balance	**N** or **P** Stroke
Now or **P**ast Back Pain	**N** or **P** Eye Pain	**N** or **P** Loss of Memory	**N** or **P** Swelling of Ankles
Now or **P**ast Breast Lump	**N** or **P** Fatigue	**N** or **P** Loss of Smell	**N** or **P** Swollen Joints
Now or **P**ast Bronchitis	**N** or **P** Frequent Urination	**N** or **P** Loss of Taste	**N** or **P** Thyroid Condition
Now or **P**ast Bruise Easily	**N** or **P** Irregular Menstrual	**N** or **P** Nosebleeds	**N** or **P** Tuberculosis
Now or **P**ast Cancer	**N** or **P** Hemorrhoids	**N** or **P** Pacemaker	**N** or **P** Ulcers
Now or **P**ast Chest Pain	**N** or **P** High BP	**N** or **P** Poor Posture	**N** or **P** Varicose Veins
Now or **P**ast Cold Extremities	**N** or **P** Insomnia		

Surgeries:

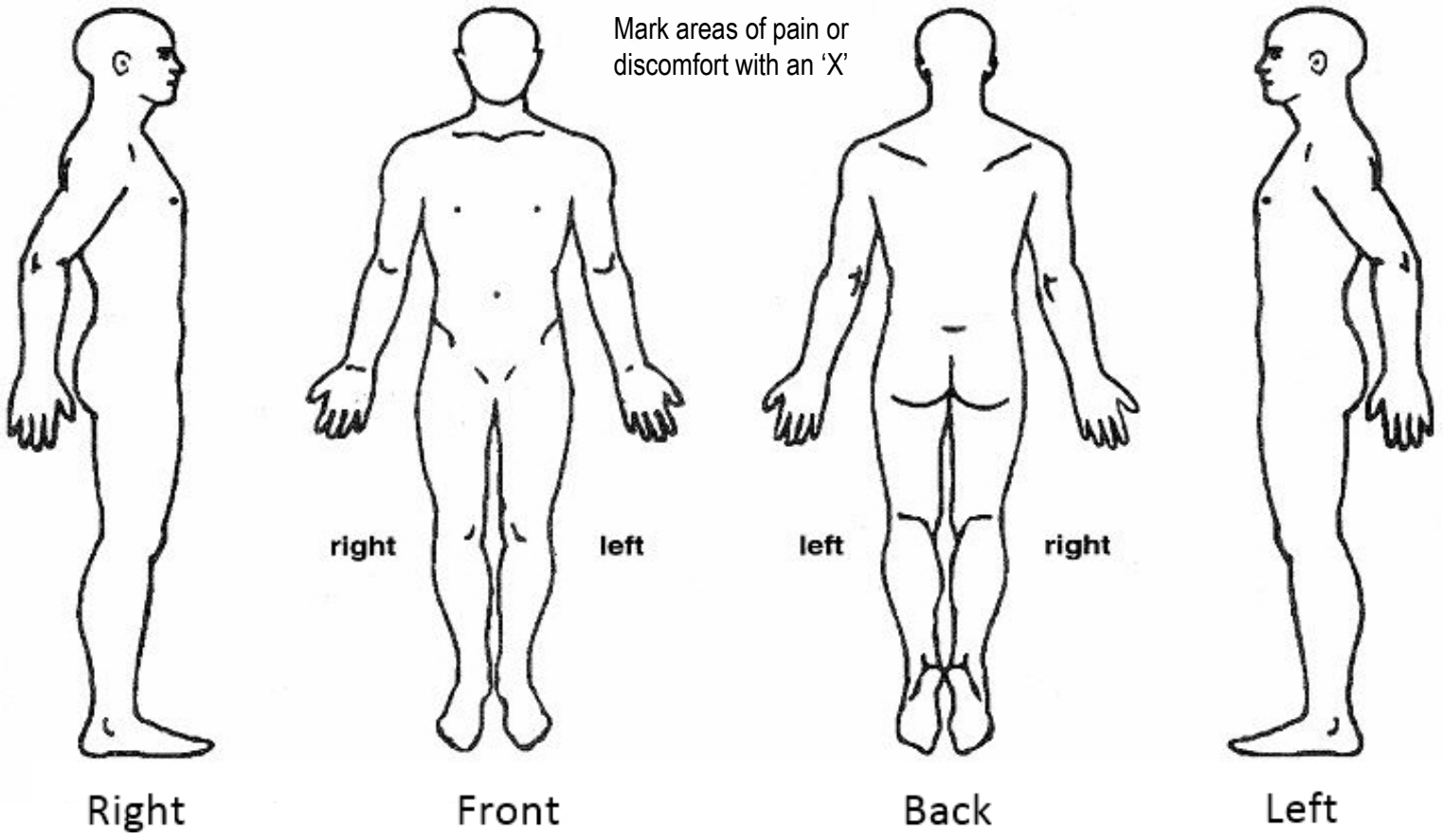
Illnesses:

Accidents, Falls, Traumas

Do you smoke? Y or N **Do you drink alcohol? Y or N** **Do you drink tea, coffee, or soda? Y or N**

Medications/Supplements:

Allergic Reactions to Medicine:



Primary Complaint:		
When did you first notice it?		
What were you doing?		
Where is the symptom?		
Where does it travel?		
Sharp Dull Aching Burning Numb Throbbing Radiating (circle)	**☺ 1-2-3-4-5-6-7-8-9-10**	**When 25% 50% 75% 100%**
What makes it better?	**What makes it worse?**	
Difficult movements?	**Difficult activities?**	
What have you tried?	**Have you had this symptom before?**	

Bountiful Life Chiropractic Center
Functional Rating Index (FRI)

In order to properly assess your condition, we must understand how your **neck and/or back problems** have affected your ability to manage every day activities. For each item below, **please circle the answer which most closely describes your condition today**.

Office Use Only:
Score _____
% _____

Name: _____ **Date:** _____

1. Pain Intensity	No pain (0)	Mild pain (1)	Moderate pain (2)	Severe pain (3)	Worst possible pain (4)
2. Sleeping	Perfect sleep (0)	Mildly disturbed sleep (1)	Moderately disturbed sleep (2)	Greatly disturbed sleep (3)	Totally disturbed sleep (4)
3. Personal Care (washing, dressing, etc.)	No pain, no restrictions (0)	Mild pain, no restrictions (1)	Moderate pain, need to go slowly (2)	Moderate pain, need some assistance (3)	Severe pain, need 100% assistance (4)
4. Travel (driving, riding in vehicle, etc.)	No pain on long trips (0)	Mild pain on long trips (1)	Moderate pain on long trips (2)	Moderate pain on short trips (3)	Severe pain on short trips (4)
5. Work	Can do normal work plus unlimited extra work (0)	Can do normal work, no extra work (1)	Can do 50% of normal work (2)	Can do 25% of normal work (3)	Cannot work (4)
6. Recreation	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do few activities (3)	Cannot do any activities (4)
7. Frequency of pain	No pain (0)	Occasional pain, 25% of day (1)	Intermittent pain, 50% of day (2)	Frequent pain, 75% of day (3)	Constant pain, 100% of day (4)
8. Lifting	No pain with heavy weight (0)	Increased pain with heavy weight (1)	Increased pain with moderate weight (2)	Increased pain with light weight (3)	Increased pain with any weight (4)
9. Walking	No pain, any distance (0)	Increased pain after 1 mile (1)	Increased pain after ½ mile (2)	Increased pain after ¼ mile (3)	Increased pain, any distance (4)
10. Standing	No pain after several hours (0)	Increased pain after several hours (1)	Increased pain after 1 hour (2)	Increased pain after ½ hour (3)	Increased pain with any standing (4)

Bountiful Life Chiropractic Center Terms of Acceptance

Chiropractic has only one goal - to serve the health needs of you, the patient. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine, as well as extremities.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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.

Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, then do an analysis, and then develop a treatment for the extremity and synchronize this plan with the plan for the spinal treatment.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral.

We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient. We are here for your 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. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

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 affect 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 patient 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, our office has the right to refuse to give care.

X-ray Release

This is to certify that Dr. LaBounty, Dr. Deal, & Dr. Larson have my permission to perform an X-ray evaluation. **To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child.** Date of last menstrual period:_____

Consent to Care for Minor

I authorize Dr. LaBounty, Dr. Deal, & Dr. Larson to administer care as they so deem necessary to my minor dependent.

Payment / Insurance

I understand that Dr. LaBounty, Dr. Deal, and Dr. Larson will provide a receipt to assist me in making collection from any insurance company. I clearly understand 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read and understand the above and I agree to these policies and procedures. All questions about this page have been answered to my satisfaction and I therefor accept care at Bountiful Life Chiropractic Center on this basis. Check all that apply:

☐ Terms of Acceptance ☐ Patient Health Information ☐ Consent Form ☐ X-ray Release ☐ Minor Consent

Signature: **Date:**