WELCOME...
to Baker-Borski Chiropractic

PATIENT INFORMATION Today's Date _____

Patient Name _____ Patient SS# _____
Address _____
_____
City State Zip
Sex: ☐ M ☐ F Age _____ Birthdate _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other _____
Occupation _____ Employer _____
Employer Address _____ Phone _____
Spouse's Name _____ Birthdate _____
Spouse's SS# _____ Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____ Work _____ Ext. ____ email address_____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT:
Name _____ Relationship _____
Home Phone _____ Work Phone _____ Ext. _____

INSURANCE

Who is responsible for this account? _____
Relationship to patient _____
Insurance Co. _____ Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____ Birthdate _____
SS# _____ Relationship to patient _____
Insurance Co. _____ Group # _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____
Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____
To whom have you made a report of your accident? ☐ Auto Insurance
☐ Employer ☐ Worker Comp. ☐ Other _____
Attorney Name (if applicable) _____

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications
☐Surgery ☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other
Name and address of other doctor(s) who have treated you for your condition
_____
Date of last physical exam _____

HEALTH HISTORY (cont.)

S = SELF M = MOTHER F = FATHER S/B = SIBLING
Please indicate which conditions have been experienced by the above by checking the appropriate boxes.

S	M/F	S/B		S	M/F	S/B		S	M/F	S/B	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	hepatitis	☐	☐	☐	reproductive disorder
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV / ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK HISTORY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Month _____
☐ Caffeine Cups/Day _____
☐ High Stress Reason _____

Any children? ☐ Yes ☐ No Date(s) of birth: _____
Are you currently pregnant? ☐ Yes ☐ No Due Date _____
What is your current weight? _____ lbs., and height, _____Ft. _____In.

Injuries / Surgeries you have had	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken Bones	_____	_____
Dislocation	_____	
Surgeries	_____	_____

Accident History					
	☐ Job	☐ Auto	☐ Other _____	_____
	☐ Job	☐ Auto	☐ Other _____	_____
	☐ Job	☐ Auto	☐ Other _____	_____

List any medication, vitamins, herbs, and/or minerals you are presently taking _____
_____
_____

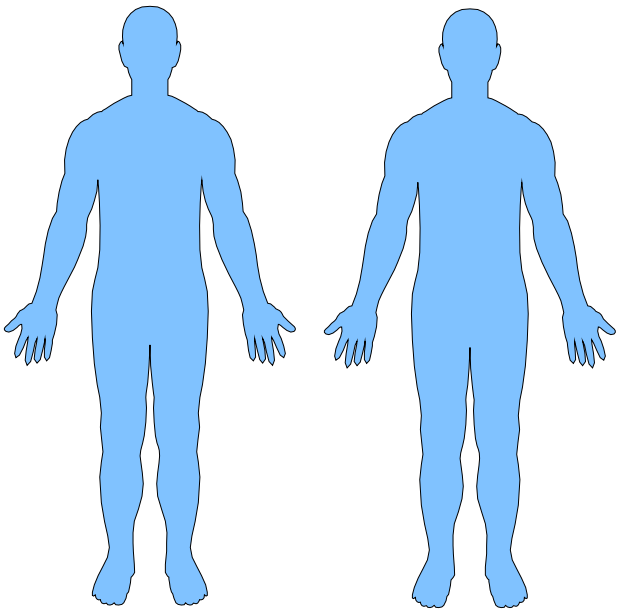
Do you have any allergies? _____

Number of hours you sleep at night _____ Sleep on: ☐ Back ☐ Sides ☐ Front

Type, age, and condition of mattress _____

Pillow: ☐ Thick ☐ Medium ☐ Thin Type: ☐ Feather ☐ Foam ☐ Other _____

PATIENT CONDITION



FRONT **BACK**

Please describe present major complaints _____
_____
_____
When did your symptoms appear? _____
_____
Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown

Circle and label the areas of your discomfort on the pictures. Please use the following letters to symbolize the types of pain you are experiencing:
N = Numbness P = Pins & Needles B = Burning
A = Aching S = Stabbing T = Throbbing
D = Dull H = Shooting O = Other
RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (SEVERE PAIN).
_____

How often do you have this pain? _____
Is it constant or does it come and go? _____

Symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Night

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please check the following activities that aggravate your condition: ☐ Bending ☐ Reaching ☐ Straining at stool ☐ Coughing ☐ Sitting ☐ Turning head ☐ Lifting ☐ Sneezing ☐ Walking ☐ Lying down ☐ Standing

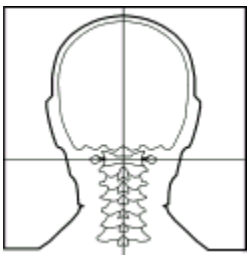
Please check the following activities that relieve your condition: ☐ Bending ☐ Sitting ☐ Lifting ☐ Standing ☐ Lying Down ☐ Turning head ☐ Reaching ☐ Walking

Please check any additional symptoms you may be experiencing:

☐ Blurred Vision	☐ Face flushed	☐ Low resistance to colds
☐ Buzzing in ears	☐ Fainting	☐ Muscle jerking
☐ Cold feet	☐ Fatigue	☐ Numbness in fingers
☐ Cold hands	☐ Fever	☐ Numbness in toes
☐ Cold sweats	☐ Head seems heavy	☐ Pins & Needles in arms
☐ Concentration loss	☐ Headaches	☐ Pins & needles in legs
☐ Confusion	☐ Insomnia	☐ Ringing in ears
☐ Constipation	☐ Light bothers eyes	☐ Shortness of breath
☐ Depression	☐ Loss of balance	☐ Stiff neck
☐ Diarrhea	☐ Loss of smell	☐ Stomach upset
☐ Dizziness	☐ Loss of taste	

AUTHORIZATION
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
SIGNATURE OF PATIENT (or parent if a minor) DATE



BAKER•BORSKI CHIROPRACTIC S.C.
2809 Merrill Avenue
Wausau, WI 54401
(715) 675-4106

FINANCIAL PAYMENT AGREEMENT:

As a courtesy to our patients, insurance claims will be filed for you. **We require full payment of deductibles and co-payments at the time of service.** Please remember that you are responsible for full payment of your account regardless of insurance coverage. An insurance policy is a contract strictly between the insurance company and you, the policyholder. Therefore, after the initial follow-up, any problems with the insurance company will be your responsibility. Please let us know if we can be of assistance.

If you discontinue care prior to the completion of your prescribed care plan, your bill will be due, IN FULL, within 30 days. A 1% late fee per month will be assessed on all overdue balances beyond 30 days of receipt of your statement. If the account is not paid within 60 days of the date of services, and no financial arrangement has been made, your account will be sent to collections.

Accepted methods of payment are as follows: cash, money order, MasterCard, and VISA. We will happily accept your personal check as a method of payment. If, however, your check is returned by your bank due to non-sufficient funds, we will charge your account $15.00 and no longer accept personal checks from you.

I have read and understand the full office policy for payment addendum as given to me. All my questions have been fully answered. I hereby authorize payments of benefits directly to the provider of benefits due to me for services rendered. If payment for services rendered is not received within 30 days of filing, I am responsible for paying all charges at that time in full. My credit/debit card (on file) will be billed at the time for services in full. This applies also to Medicare and secondary/supplemental insurance if they deny payment as well.

If I have been involved in a work-related injury and my claim is denied by my employer's worker's compensation carrier, I accept full responsibility for my care and account and understand payment is due in full immediately.

If I have been involved in an automobile accident or other personal injury I accept full financial responsibility for my care at the time of service. I understand that it is my responsibility to collect from the insurance company independent of the final deposition of my case.

Signed:_____ **Date:**_____

INFORMED CONSENT:

My signature below affirms that I authorize chiropractic care for myself and/or my dependent(s) by Dr. Michael J. Borski and Dr. Robin L. Baker.

Signed:_____ **Date:**_____