Byers Chiropractic Center

139 North State Route 42 Waynesville, OH 45068
Phone: 513-897-0997 **Fax:** 513-897-1678 **Website:** www.DrJimByers.com

Patient Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
City, ZIP Code: _____ Cell Phone: _____
SSN: _____ Cell Carrier: _____
Email: _____ Sex: M / F
Date of Birth: _____ Marital Status: _____

If using insurance, please list Insurance Provider: _____
Who may we thank for referring you to our Office: _____

Missed Appointments

There will be a $30.00 missed appointment fee for all appointments not cancelled with a 24-hour notice.

Delinquent Accounts

I understand any outstanding unpaid bill 90 days overdue will incur an additional 30% delinquency fee, will be sent to an outside collection agency, and will be charged attorney fees if it goes to court.

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above listed and hereby assign at clinic's request, and convey directly to Byers Chiropractic Center all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under my applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable requested for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment as to be considered as valid as the original. I have read and fully understand this agreement.

I have reviewed the Notice of Privacy Practices (HIPPA) Sheet.

Signature or Insured / Guardian: _____ Date: _____

Revisions 09/2023

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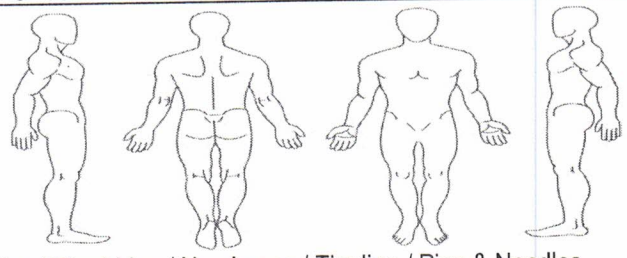
Case History

Name: _____ Date: _____

1. Circle the Severity (0 = No Pain to 10 = Very Severe Pain) & Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain)



2. Symptoms are worse in the (circle what applies)
   - Morning - Increase during the day
   - Afternoon - Same all day
   - Night - Decrease during the day
3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptom begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? _____ Improved _____ Gotten Worse _____ Stayed the same since it began
10. Circle the thing that make your problems worse:

    Bending / Lying / Walking / Standing / Sitting / Movement / Twisting / Lifting / Sleeping / Driving

11. Is there anything you can do to relieve the problems? ____No ____Yes, Describe: _____

    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? _____Good _____ Poor Comments: _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____Work ____Sleep ____ Daily Routine ____ Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

    _____
18. Any other musculoskeletal problems? ___ No ___ Yes Neurological Problems? ___ No ___ Yes

**Additional Information on back of sheet _____

I certify that the above information is accurate to the best of my knowledge.

Patient / Guardian Signature: _____ **Date:** _____

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Patients Name: _____ Date: _____

CONFIDENTIAL HEALTH HISTORY

Please place a check in the box next to the following items if you are currently experiencing these problems or have ever seen a doctor about these problems.

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Loss or Gain
- ☐ Allergies
- ☐ Bleeding Problems
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid Disease/Goiter
- ☐ Alcoholism
- ☐ Drug Abuse

EYE, EAR, NOSE, THROAT
- ☐ Poor Vision
- ☐ Pain in Eye(s)
- ☐ Deafness/Difficulty Hearing
- ☐ Nosebleeds
- ☐ Nose Problems
- ☐ Sinus Trouble
- ☐ Dental Problems
- ☐ Hoarseness
- ☐ Tonsillectomy

GASTROINTESTINAL
- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Difficulty Swallowing
- ☐ Belching or Gas
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Pain Over Abdomen
- ☐ Ulcer
- ☐ Black or Bloody Stools
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Jaundice
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

MEN ONLY
- ☐ Testicular Swelling/Pain
- ☐ Prostate Problems

RESPIRATORY
- ☐ Difficulty Breathing
- ☐ Chronic Cough
- ☐ Spitting Phlegm
- ☐ Spitting Blood
- ☐ Wheezing/Asthma
- ☐ Pneumonia
- ☐ Tuberculosis

CARDIOVASCULAR
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Pain Over Heart
- ☐ Previous Heart Trouble
- ☐ Ankle Swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Stroke

GENITOURINARY
- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Disease
- ☐ Urinary Infection
- ☐ Inability to Control Urination
- ☐ Difficulty Starting Urine Flow
- ☐ Get Up ___ Times Per Night to Urinate
- ☐ Venereal Infection
- ☐ Sexual Difficulties
- ☐ Breast Lump or Pain

SKIN
- ☐ Itching
- ☐ Bruising Easily
- ☐ Change in Mole(s)
- ☐ Skin Cancer

WOMEN ONLY
- ☐ Painful Periods
- ☐ Excessive Flow
- ☐ Irregular Cycles
- ☐ Vaginal Burning/Itching
- ☐ Hot Flashes
- ☐ Date Last Period Began _____
- ☐ Date of Last Pap Test _____
- ☐ Hysterectomy

NEUROLOGIC
- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Numbness/Tingling
- ☐ Arm/Leg Pain
- ☐ Mental Disorder

MUSCULOSKELETAL
- ☐ Neck Stiffness/Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Swollen Joints
- ☐ Muscle Aches/Soreness
- ☐ Spinal Curvature
- ☐ Arthritis

HABITS
- ☐ Smoking _____Packs Per Day
- ☐ Drinking
- ☐ Recreational Drug Use

EXERCISE
- ☐ None
- ☐ 1-2 Times per Week
- ☐ 3-5 Times per Week
- ☐ 6-7 Times per Week

FAMILY HISTORY

Include information on your brothers, sisters, parents and grandparents. **NOT INCLUDING YOURSELF!**
- ☐ Diabetes
- ☐ Thyroid Disease/Goiter
- Tuberculosis
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Muscle, Bone or Nerve Disease

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The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is key. Please read the below and if you have any questions, please ask one of our staff members.

Informed Consent

A patient, coming into the Chiropractor Doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractor adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from; latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractor physician. The chiropractic doctor providers a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient at Byers Chiropractic Center, I am authorizing them to proceed with any treatment that they are deem necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request.

Women Only

To the best of my knowledge, I am / am NOT Pregnant (circle one) and give permission / do not give permission to X-RAY me for diagnostic interpretation.

For Minors

I, _____ being the patient 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.

Communications

In the event that we would need to communicate your healthcare information, to whom may we do so?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

No One: [ ]

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machine or voicemail? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have received the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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ATTENTION PATIENTS:

During most New Patient initial visits, I will take a history, perform a physical Exam and take a diagnostic X-Ray film. I will always provide an initial read of the film. In most cases a second opinion would be helpful to re-confirm my initial diagnosis. In order to provide a complete treatment plan, I am recommending the second opinion be read by a Board Certified Chiropractic Radiologist. Your films will be forwarded to Dr. Gregerson for a second opinion if I feel necessary.

I thank you for your understanding in this matter.
Dr. James K. Byers

Gregerson Radiology Consultants

8004 Red Fox Rd, Stanwood, MI 49346
Tele: (630) 854-3367 / Fax: (630) 578-1018
e-mail: gregradconsults@gmail.com

I understand that it is my doctor's policy to have the x-rays taken in his office and have them interpreted by a Board Certified Radiologist in order to provide me with the best quality care. I accept that a fee will be charged for the interpretation of my x-rays, independent from any financial agreement made with my referring doctor, and that I am personally responsible for this fee. I understand that, if applicable, my insurance company may be billed directly by **Gregerson Radiology Consultants** and that I am personally responsible for any portion of my bill not met by my particular policy, no matter what reason. I assign and authorize direct payment of any insurance benefits to be paid directly to **Gregerson Radiology Consultants** for their professional radiology services. I also authorize release of any medical information concerning my case.

_____ _____
Signature of patient / patient representative Date

_____ _____
Relationship to patient Date

Revisions 06/2020