

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

**Privacy Practices:**

I have received a copy of the Notice of Privacy Practices for Back to Heath Chiropractic

\_\_\_\_\_ **patient initials**

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, as well as how you may have access to the information.

**We may share your health information to:**

- treat you
- discuss your case with family
- As a teaching institution, discuss your case with interns and consult with other colleagues
- collect payment
- do research
- run our office
- include you in care classes
- inform you about other services
- thank you for referring other patients

**We may use your health information for:**

- health and safety reasons
- reporting to worker's compensation
- reporting to law officials
- reporting victims of abuse
- teaching / Instruction
- court hearings and filings

**You have the right to:**

- request confidential communications
- ask us to limit information sharing
- request a list of whom we share your health information with
- request a copy of your health record (an additional fee may be involved)
- amend your protected health information
- advise our management if you believe your privacy rights have been violated

\_\_\_\_\_ **patient initials**

**These privacy practices are effective: January 18, 2010**  
**For further information please contact: Dr. Derek Carroll, 970-635-2848**

**Consultation & Exam**

To begin today's visit, you will be asked to complete confidential health information for us to discuss with you. To learn more about your condition, we will perform preliminary examinations which may include a physical examination, x-rays, and laboratory tests.

If we believe that we may be able to help you, we will give you a report of our findings and recommend a treatment plan. As you advance through treatment, periodic progress evaluations will measure and compare your improvement. We will always inform you of associated fees before we perform any procedure or service.

Office Use Only:

\_\_\_\_\_  
 Doctor's Signature

\_\_\_\_\_  
 Date

I understand and agree to the above information:

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name- patient or guardian

\_\_\_\_\_  
 Signature- patient or guardian

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

## confidential health information

### 1 PATIENT INFORMATION

clinic id	date
-----------	------

last name	first name	m.i.
-----------	------------	------

### 2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident?  yes  no

What services interest you? (mark all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> injury prevention                                 | <input type="checkbox"/> treatment for pain                 | <input type="checkbox"/> patient education classes             |
| <input type="checkbox"/> balance and coordination training                 | <input type="checkbox"/> spinal and body alignment          | <input type="checkbox"/> body composition counseling           |
| <input type="checkbox"/> range of motion, mobility, or flexibility therapy | <input type="checkbox"/> strengthening and stamina exercise | <input type="checkbox"/> nutritional and supplement counseling |
- other: \_\_\_\_\_

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel?  dull/achy  sharp  numb  tingling  burning  cold

How often do you experience the **primary** complaint?  constantly  daily  weekly  monthly  yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1 no pain or discomfort	2 slight discomfort	3 pain that does not affect my activity	4 pain that affects my daily activities	5 pain that prevents performing my daily activities	6 pain that limits my work schedule	7 pain that prevents working at all	8 pain that prevents working and all personal activity	9 pain that keeps me bed ridden	10 pain that causes thoughts of suicide
-------------------------	---------------------	---	---	---	-------------------------------------	-------------------------------------	--	---------------------------------	---

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

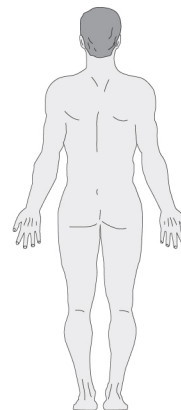
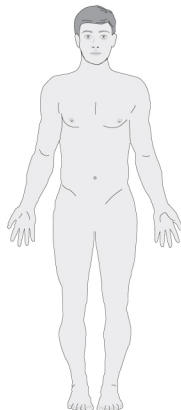
List other health complaints (2-5) on the following lines.

2	4
3	5

Do you have any other condition other than what brings you here?  yes  no  
If YES, list it here:

Please mark the areas of all of your complaints on the diagrams to the right. Include any descriptors or comments, concerning your health complaints that were not mentioned above.

- N** = numbness
- T** = tingling
- P** = pain
- W** = weakness



### 3 LIFESTYLES & HABITS

How many hours of television do you watch a day?  < 1  1-3  3-5  >5

Do you usually snack while watching television?  yes  no

How many hours per day do you use a computer at work or home?  < 1  1-3  3-5  >5

How many hours per day do you ride in a car or other vehicle?  < 1  1-3  3-5  >5

How often do you exercise?  daily  3x's/week  2x's/week  1x/week  I don't exercise

How long do your exercise work outs last?  >1 hour  1 hour  30 minutes  < 30 minutes  NA

What are your exercise activities? (mark all that apply)  I don't exercise

walking  swimming  weight lifting

stretching/flexibility  yoga/Pilates  resistance bands

running/treadmill/rowing/climbing  group exercise classes  other \_\_\_\_\_

Do you take a multi-vitamin?  yes  no If YES, what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

Have you ever used tobacco?  never  daily  weekly  monthly  yearly

How many servings of alcohol do you drink each week?  0  1-2  3-5  >5

How many servings of coffee do you drink each week?  0  1-2  3-5  >5

How many servings of soda do you drink each week?  0  1-2  3-5  >5

### 4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
heart problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
kidney problems	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
cancer	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
headaches	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
back pain	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
obesity	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister
poor conditioning	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	mother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	father	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	brother	<input type="checkbox"/> n <input type="checkbox"/> p <input type="checkbox"/> c	sister

### 5 CONDITIONS

Mark the following conditions as they currently pertain to you.

alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	low back pain	<input type="checkbox"/> yes <input type="checkbox"/> no	polio	<input type="checkbox"/> yes <input type="checkbox"/> no
anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	goiter	<input type="checkbox"/> yes <input type="checkbox"/> no	measles	<input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	mental disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV positive	<input type="checkbox"/> yes <input type="checkbox"/> no	mumps	<input type="checkbox"/> yes <input type="checkbox"/> no	venereal infection	<input type="checkbox"/> yes <input type="checkbox"/> no
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	influenza	<input type="checkbox"/> yes <input type="checkbox"/> no	pleurisy	<input type="checkbox"/> yes <input type="checkbox"/> no	whiplash	<input type="checkbox"/> yes <input type="checkbox"/> no
		diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough	<input type="checkbox"/> yes <input type="checkbox"/> no

## 6 INJURIES

List any **auto collisions** that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any **job injuries** that you experienced below. Begin with the most recent.

type of job injury	type of treatment received	date of job injury
1.		
2.		
3.		

List any **sports injuries** that you experienced below. Begin with the most recent.

type of sports injury	type of treatment received	date of sports injury
1.		
2.		
3.		

List any **other injuries** caused by falls or impacts. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		

## 7 HOSPITAL / MEDICINE

Have you had breast implant surgery?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Have you had knee or hip replacement surgery?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have a pacemaker?	<input type="checkbox"/> yes	<input type="checkbox"/> no
Do you have any other implantable medical devices in your body?	<input type="checkbox"/> yes	<input type="checkbox"/> no

Mark all of the following procedures as they pertain to you.					
vaccinations	<input type="checkbox"/> yes	<input type="checkbox"/> no	tubes in ears	<input type="checkbox"/> yes	<input type="checkbox"/> no
tonsillectomy	<input type="checkbox"/> yes	<input type="checkbox"/> no	appendectomy	<input type="checkbox"/> yes	<input type="checkbox"/> no
gall bladder removal	<input type="checkbox"/> yes	<input type="checkbox"/> no	female/male surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
back surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____		
			rectal surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
			sinus surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
			hernia surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
			thyroid surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no
			stomach surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory?	<input type="checkbox"/> yes	<input type="checkbox"/> no	Were you ever knocked unconscious?	<input type="checkbox"/> yes	<input type="checkbox"/> no
--------------------------------------	------------------------------	-----------------------------	------------------------------------	------------------------------	-----------------------------

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection?	<input type="checkbox"/> yes	<input type="checkbox"/> no
---	------------------------------	-----------------------------

## 8 SYSTEM REVIEW

Mark the following conditions that are **currently** a cause of significant concern for you.

### General

<input type="checkbox"/> consistent fainting	<input type="checkbox"/> chills	<input type="checkbox"/> convulsions	<input type="checkbox"/> depression	<input type="checkbox"/> dizziness
<input type="checkbox"/> loss of weight	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> headache	<input type="checkbox"/> loss of sleep
<input type="checkbox"/> weight gain	<input type="checkbox"/> neuralgia	<input type="checkbox"/> night sweats	<input type="checkbox"/> wheezing	<input type="checkbox"/> nervousness

### Gastro-Intestinal

<input type="checkbox"/> constipation	<input type="checkbox"/> diarrhea	<input type="checkbox"/> gall bladder problems	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> jaundice
<input type="checkbox"/> liver problems	<input type="checkbox"/> nausea	<input type="checkbox"/> stomach pain	<input type="checkbox"/> poor appetite	<input type="checkbox"/> poor digestion
<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> vomiting	<input type="checkbox"/> vomiting blood		

### Eye/Ear/Nose/Throat

<input type="checkbox"/> asthma	<input type="checkbox"/> crossed eyes	<input type="checkbox"/> deafness	<input type="checkbox"/> earache	<input type="checkbox"/> ear discharge
<input type="checkbox"/> ear noises	<input type="checkbox"/> enlarged thyroid	<input type="checkbox"/> frequent colds	<input type="checkbox"/> hay fever	<input type="checkbox"/> hoarseness
<input type="checkbox"/> nasal obstruction	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> pain in eyes	<input type="checkbox"/> poor vision	<input type="checkbox"/> sinusitis
<input type="checkbox"/> sore throat	<input type="checkbox"/> tonsillitis			

### Respiratory

<input type="checkbox"/> chest pain	<input type="checkbox"/> chronic cough	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> spitting blood	<input type="checkbox"/> spitting phlegm
-------------------------------------	--	---	---	--

### Muscles/Joints/Bones

<input type="checkbox"/> backache	<input type="checkbox"/> foot problems	<input type="checkbox"/> pain bet. shoulders	<input type="checkbox"/> painful tailbone	<input type="checkbox"/> stiff neck
<input type="checkbox"/> spinal curvature	<input type="checkbox"/> swollen joints	<input type="checkbox"/> tremors	<input type="checkbox"/> twitching	<input type="checkbox"/> weakness

### Cardio-Vascular

<input type="checkbox"/> ankle swelling	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> heart trouble	<input type="checkbox"/> pain over heart
<input type="checkbox"/> poor circulation	<input type="checkbox"/> rapid heart	<input type="checkbox"/> slow heart	<input type="checkbox"/> strokes	

### Skin or Allergies

<input type="checkbox"/> bruise easily	<input type="checkbox"/> dryness	<input type="checkbox"/> eczema	<input type="checkbox"/> hives	<input type="checkbox"/> itching
<input type="checkbox"/> sensitive skin				

### Women

<input type="checkbox"/> cramps	<input type="checkbox"/> excessive flow	<input type="checkbox"/> hot flashes	<input type="checkbox"/> irregular cycle	<input type="checkbox"/> painful periods
---------------------------------	---	--------------------------------------	--	--

## 9 PREGNANCY

### WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant let the doctor or assistant know right now.

Are you pregnant?  yes  no      On what date did your last period begin? \_\_\_\_\_

Do you want to take a pregnancy test now?  yes  no

OFFICE USE ONLY

result of clinic pregnancy test:    +    -

Mark the following situations as they pertain to you.

tubal ligation	<input type="checkbox"/> yes <input type="checkbox"/> no	complete or partial hysterectomy	<input type="checkbox"/> yes <input type="checkbox"/> no	partner had a vasectomy	<input type="checkbox"/> yes <input type="checkbox"/> no
less than 10 days since the start of my last period	<input type="checkbox"/> yes <input type="checkbox"/> no	taking birth control pills	<input type="checkbox"/> yes <input type="checkbox"/> no		

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

\_\_\_\_\_  
patient or guardian signature

\_\_\_\_\_  
date



# Registration & Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

## confidential health information

File # / Clinic ID	Date
--------------------	------

### 1 PATIENT INFORMATION

last name		first name		m.i.	
age	date of birth	social security #	gender	<input type="checkbox"/> male	<input type="checkbox"/> female
status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> partnered <input type="checkbox"/> widowed <input type="checkbox"/> separated <input type="checkbox"/> divorced					
street			city	state	zip
work phone	extension	home phone	cell phone	e-mail	
spouse or guardian last name		first name		m.i.	date of birth

### 2 EMERGENCY CONTACT

last name	first name	relationship	home phone	work phone	cell phone
last name	first name	relationship	home phone	work phone	cell phone

### 3 PATIENT EMPLOYMENT

employer name	occupation		
address street	city	state	zip

### 4 QUESTIONS

Who referred you to us?

How did you hear about our clinic?

Are you here because you were involved in a vehicle collision?  yes  no

Are you here because you were injured at your place of employment?  yes  no

Are you here because you were involved in another type of accident?  yes  no

Will you be using health insurance to supplement payment to our office\*?  yes  no

\* If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION sections of this form.

### 5 INSURANCE COVERAGE

types of insurance					
<input type="checkbox"/> employee group health plan	<input type="checkbox"/> personal health insurance	<input type="checkbox"/> health savings account	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	
<input type="checkbox"/> personal injury	<input type="checkbox"/> Work's Compensation	<input type="checkbox"/> TRICARE/CHAMPS	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> FECA	
primary insurance company	primary ins. ID #	primary ins. group #			
secondary insurance company	secondary ins. ID #	secondary ins. group #			

I understand and agree to the following:

- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional services may be recommended and I will be advised of applicable costs
- There is no guarantee that my health insurance will pay for all or any part of my care
- As the patient or guardian of a patient, I am ultimately responsible for all charges incurred for services rendered
- All payments are due at the time services are rendered

\_\_\_\_\_

patient or guardian signature

\_\_\_\_\_

Date



**6 INSURED'S INFORMATION**

last name		first name			m.i.	
street				city	state	zip
employer	age	date of birth	social security #		gender <input type="checkbox"/> male <input type="checkbox"/> female	
Relationship to patient						
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____						

**7 BENEFITS ASSIGNMENT & INFORMATION RELEASE**

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

- All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
- Amounts owed on my behalf from proceeds of any settlement related to my case.

\_\_\_\_\_

Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

\_\_\_\_\_

Patient or guardian signature Date

**OFFICE USE ONLY:**

Patient: last name	first name	m.i.	date of birth
--------------------	------------	------	---------------

**INSURANCE VERIFICATION**

<p><b>Person's name that you spoke to?</b></p> <p>Last: _____ First: _____  ID # _____ Extension: _____</p> <hr/> <p>Does the plan have a <b>deductible</b>? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Amount for an individual: _____  Amount for the family: _____  Amount currently met: _____</p> <p>After deductible, what % of services do you cover? _____  When does the deductible renew? _____</p> <hr/> <p>Does the patient have a <b>co-pay</b>? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Amount for the co-pay: _____</p> <hr/> <p>What is the max. yearly <b>benefit</b>? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Does the company <b>assign benefits</b> to the doctor? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>What is the <b>yearly visit cap</b>? _____</p> <p>Are any <b>special forms</b> required to file claims? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p><b>Auto Collision or Personal Injury case?</b> <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Reported to the insurance company? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Has an application for benefits been filed? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Did the police write a report? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Is auto or PI insurance primary? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Agent name and contact info: _____</p> <hr/> <p><b>Workers' Comp case?</b> <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Has the injury been reported? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Name: _____  Title: _____</p> <p>Is patient currently employed at place of injury? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Name of person authorizing care: _____</p>																
<p>Does the plan cover the following <b>services</b>?</p> <table border="0"> <tr> <td>Chiropractic Adjustments</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td>Therptc. Exercise, Therptc. Activity &amp; Neuro Myo Reedu.</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td>Modalities by a Chiropractor</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td>Orthotics, supports, pillows and</td> <td></td> </tr> <tr> <td>X-rays: _____</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td>Nutritional supplements?</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> <tr> <td></td> <td></td> <td>Other: _____</td> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> </tr> </table>		Chiropractic Adjustments	<input type="checkbox"/> yes <input type="checkbox"/> no	Therptc. Exercise, Therptc. Activity & Neuro Myo Reedu.	<input type="checkbox"/> yes <input type="checkbox"/> no	Modalities by a Chiropractor	<input type="checkbox"/> yes <input type="checkbox"/> no	Orthotics, supports, pillows and		X-rays: _____	<input type="checkbox"/> yes <input type="checkbox"/> no	Nutritional supplements?	<input type="checkbox"/> yes <input type="checkbox"/> no			Other: _____	<input type="checkbox"/> yes <input type="checkbox"/> no
Chiropractic Adjustments	<input type="checkbox"/> yes <input type="checkbox"/> no	Therptc. Exercise, Therptc. Activity & Neuro Myo Reedu.	<input type="checkbox"/> yes <input type="checkbox"/> no														
Modalities by a Chiropractor	<input type="checkbox"/> yes <input type="checkbox"/> no	Orthotics, supports, pillows and															
X-rays: _____	<input type="checkbox"/> yes <input type="checkbox"/> no	Nutritional supplements?	<input type="checkbox"/> yes <input type="checkbox"/> no														
		Other: _____	<input type="checkbox"/> yes <input type="checkbox"/> no														
<p><b>Address to send claims:</b></p> <p>_____</p>																	