Bella Vista Back Center
Dr. Carol Reynolds

New Patient Form: ***Circle all that applies***

First Name	Middle	Last	Nickname
Marital Status: *Married / Not Married*	Spouse's Name	Spouse DOB	Preferred Language: *English / Other:*
Address		City	State: Zip:
Home Phone	Work Phone	Cell Phone	Email
DOB: / /	Social Sercurtiy #: - -		Gender: *Male / Female*
Race/Ethnicity:	*Native American*	*Caucasion*	*Latino/Hispanic*
Pacific Islander	*Asian*	*African American*	*Not Specifiied*
How did you hear about us?			

Your Health Data

Height:	Weight:	Blood Pressure:	Pulse:

Present & Past Illness and/or Conditions: (Circle all that Apply)

Arthritis	Fibromyalgia	Fractures	Spinal Compression Fix
Cancer	Thyroid	Hypertension	Scoliosis
Pacemake	Respiratory	Joint Replacement	Osteoporosis
Herniated Disc	Heart Disease	Diabetes	Headaches ____ /Wk

If Pregnant Due Date:	List Past Surgery(s) & Year:

Health Care Professionals seen for Current Condition?

Prescription Meds- Dose & Frequency		Medication Allergies	

Family History

Arthritis:	Heart Diease:	Scolisis:	Diabetes:
Cancer:	Hypertension:	Back Surgery:	Other:

Social History		Smoke History	Work History
Alcohol Consuption?	*Yes / No*	*Everyday*	Job Title:
Coffee Consumption?	*Yes / No*	*Occasional Smoker*	Schedule:
Soda Consumption?	*Yes / No*	*Former Smoker*	Physical Activites:
Water Consumption:	_____Glasses	*Never Smoked*	
Sleep Amount?	_____hr/night	Years Smoked:	Physical Stress of Job:
Exercise Frequency:	x _____per week	Pack Per Day:	*Low / Medium / High*
Type of Exercise		Interest in Quitting: *No / Possibly / Yes*	

Bella Vista Back Center Dr. Carol Reynolds Office # 479-855-3553
Fax # 479-855-7618

Current Condition: *(Circle all that apply)*

Print Name:			Date:
List Two Main Areas of Discomfort:	#1	Neck / Mid Back / Lower Back	
	Radiates where?		
	#2	Neck / Mid Back / Lower Back	
	Radiates where?		
What Happened?			
How Long Ago?	Days	Weeks	Months or Date:
Discomfort?	*Morning*	*Daytime*	*Evening* *Nighttime*
Describe Pain:	*Dull* *Sharp* *Throb* *Burn* *Cramp* *Ache* *Tingle* *Numb* *Other:*		
What Worsens?	*Sit / Stand / Walk / Bend / Lift*		Other:
	Sneeze / Look Up/Down / Stairs		

Discomfort Rating- Over the *past week* how would you rate the following

Your current PAIN or discomfort level?												
No Pain	0	1	2	3	4	5	6	7	8	9	10	*Worst Pain Imaginable*
How much has your pain interfied with you *Daily Activities*?												
No Interference	0	1	2	3	4	5	6	7	8	9	10	*Unable to Carry out Activites*
How much interference with your ability to take part in recreational , *Social* & Family activities?												
No Interference	0	1	2	3	4	5	6	7	8	9	10	*Unable to Carry out Activites*
How *Anxious* (Tense, uptight, irritable, difficulty concentrating) have you been feeling?												
Not at all Anxious	0	1	2	3	4	5	6	7	8	9	10	*Extremely Anxious*
How *Depressed* (down in the dumps, sad, low spirts, unhappy) have you been feeling?												
Not at all Depressed	0	1	2	3	4	5	6	7	8	9	10	*Extremely Depressed*
How has your *Work* (Both inside/outside of home) been affectd by your pain or discomfort?												
Made it No Worse	0	1	2	3	4	5	6	7	8	9	10	*Have Made it Much Worse*
How much have you been able to *Control* (reduce/help) your pain on your own?												
Complete Control	0	1	2	3	4	5	6	7	8	9	10	*No Control Whatsever*
Has your normal *Sleep* pattern been affected by your symptoms												
No Trouble Sleeping	0	1	2	3	4	5	6	7	8	9	10	*Unable to Sleep at All*
Have you been able to *Walk* or stand as much as you are accustomed to?												
No Diffculty Standing	0	1	2	3	4	5	6	7	8	9	10	*Unable to Stand or Walk*
Ability to Lift or carry any additional weight?												
Lift with No Pain	0	1	2	3	4	5	6	7	8	9	10	*Unable to Carry Anything*

Bella Vista Back Center
Dr. Carol Reynolds

Current Primary Physician: _____

Insurance Information

Please provide your insurance card for us to scan into your patient file for Bella Vista Back Center, P.A..

We will file your primary insurance for you and one additional secondary insurance for those covered by Medicare

By my signature, I authorize the release of any medical information necessary to process my insurance claims and or authorize benefits to come directly to Clinic if assigment is taken. I also give Bella Vista Back Center, P.A. permission to leave me a message in voicemail if needed to discuss health information, remind me of an appointment, or change an appointment. I also give Bella Vista Back Center permission to release private health information to the following:

Spouse / Siblings / Children

Signature: _____ Date: _____

Consent to Treat:

I hereby authorize Dr. Carol Reynolds, D.C. to treat my condition as she deems appropiate through the use of manipulation, therapy, and additional procedures as which are considered therapeutically necessary in the course of said treatment. Dr. Carol Reynolds will not be held responsible for any pre-existing medically diagnoxed conditions, nor any medical diagnosis.

Signature: _____ Date: _____

Authorized Consent for Treatment of Minor: _____

2850 Bella Vista Way
Bella Vista AR 72714

Office Phone #: 479-855-3553
Fax Phone # 479-855-7618

Bella Vista Back Center, PA
HIPAA Omnibus Rule

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Print Patient Name: _____

I acknowledge that I have been provided a copy of the currently effective Notive of Privacy. A copy of this signed, dated document shall be as effective as the orginal.

Date: _____

_____

Signature of Patient or Personal Representative

_____

Signature of Witness or Office Representative

You may refuse to sign the ackowledgement & authorization. In refusing, this practice will not be allowed to process your insurance claims.

I acknowledge that I declined the Notice of Privacy Practices provided:

Date: _____

_____

Signature of Patient or Personal Representative

_____

Signature of Witness or Office Representative

Office Use Only: I attempted to obtain written authorization of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign _____ Communication barrier _____

Emergency situation occurred with patient _____

Other (Explain): _____

_____

_____

Signuature of Office Representative