



Back to Health
Family Chiropractic

CARE FOR A BETTER LIFE

CHRISTOPHER MICHLIN, D.C., B.C.A.O.
NANCY L.B. MICHLIN, M.ED.
6324 CAMP BOWIE BOULEVARD
FORT WORTH, TEXAS 76116
817.810.9111

New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Patient Data

Name _____ Date _____ Email _____
Your email will NOT be shared with any 3d parties. It is used for occasional office announcements and promotions.
 Address _____ City _____ State _____ Zip _____
 Telephone (home) _____ (work) _____ (cell) _____
 Age _____ Birth Date _____ Social Security # _____ Number and Ages of Children _____
 Occupation _____ Employer _____
 Marital Status _____ Spouse's Name _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Health Status _____
 Emergency Contact _____ Phone _____
 Referred By _____

Current Complaints

Nature of injury: Automobile* Work Other
 Please describe _____

 Date of injury _____ Date symptoms appeared _____
 Have you ever had same condition? No Yes If yes, when? _____
 List other practitioners seen for this injury/condition _____
 Have you ever been under chiropractic care? No Yes
 If yes, please describe _____

Insurance Information

Name of party responsible for payment _____ Phone _____
 Do you have health insurance? No Yes Name of company _____
 * If an auto accident please provide:
 Insurance company name _____ Contact person _____
 Phone _____ Claim # _____

Billing Address

Name of the insured _____
 I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.
 Patient's signature _____ Date _____
 Spouse's or guardian's signature _____ Date _____



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Habits	None	Light	Moderate	Heavy
Alcohol	-	-	-	-
Coffee	-	-	-	-
Tobacco	-	-	-	-
Drugs	-	-	-	-
Exercise	-	-	-	-
Sleep	-	-	-	-
Appetite	-	-	-	-
Soft Drinks	-	-	-	-
Water	-	-	-	-
Salty Foods	-	-	-	-
Sugary Foods	-	-	-	-
Artificial Sweeteners	-	-	-	-

Have you ever suffered from:	
<ul style="list-style-type: none"> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arteriosclerosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Pain <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chest Pain/Conditions <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Cold/Tingling extremities <input type="checkbox"/> Constipation <input type="checkbox"/> Cramps <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Digestion Problems <input type="checkbox"/> Dizziness <input type="checkbox"/> Ears Ring <input type="checkbox"/> Excessive Menstruation <input type="checkbox"/> Eye Pain/Difficulties <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Headache <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Jaw Clicking/Stiffness <input type="checkbox"/> Joint Pain/Stiffness 	<ul style="list-style-type: none"> <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Loss of memory Loss of balance <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Lumps In Breast <input type="checkbox"/> Lung Problems/Congestion <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Neck Pain or Stiffness <input type="checkbox"/> Nervousness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pain Between Your Shoulders <input type="checkbox"/> Paralysis <input type="checkbox"/> Polio <input type="checkbox"/> Poor Posture <input type="checkbox"/> Prostate Trouble <input type="checkbox"/> Sciatica <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Sleep problems/insomnia <input type="checkbox"/> Spinal Curvatures <input type="checkbox"/> Stress <input type="checkbox"/> Stroke <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Pain/Infection <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other:



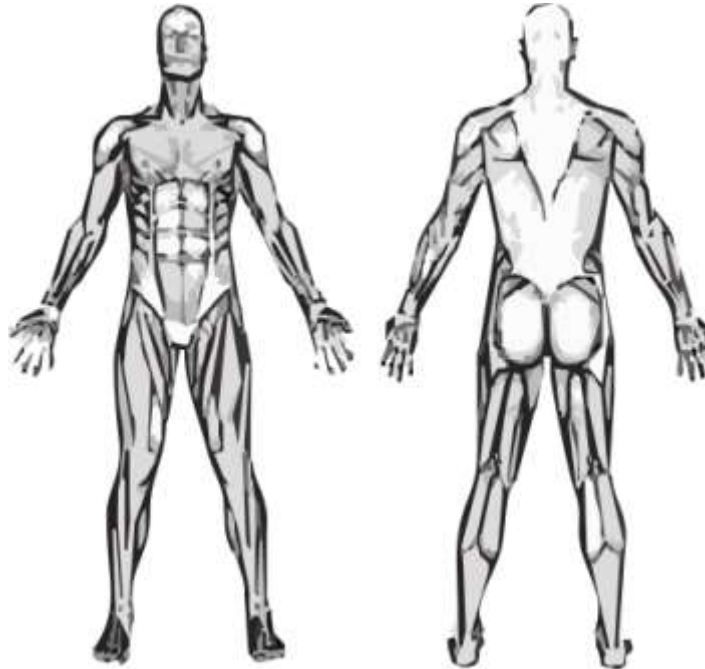
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Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A = Ache **O** = Other
B = Burning **P** = Pins & Needles
N = Numbness **S** = Stabbing





Symptom Survey Form

Patient _____ Doctor _____ Date _____

Birth Date ____/____/____ Approx Weight _____ Vegetarian: Yes No

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

- * Fill in the circle marked 1 for MILD symptoms (occur once or twice a year).
- * Fill in the circle marked 2 for MODERATE symptoms (occur several times a month).
- * Fill in the circle marked 3 for SEVERE symptoms (you are aware of it almost constantly).
- * Leave circles BLANK if you do not deal with that symptom. *

GROUP ONE

1 <input type="radio"/> <input type="radio"/> <input type="radio"/> Acid foods upset	8 <input type="radio"/> <input type="radio"/> <input type="radio"/> Gag easily	15 <input type="radio"/> <input type="radio"/> <input type="radio"/> Appetite reduced
2 <input type="radio"/> <input type="radio"/> <input type="radio"/> Get chilled often	9 <input type="radio"/> <input type="radio"/> <input type="radio"/> Unable to relax; startles easily	16 <input type="radio"/> <input type="radio"/> <input type="radio"/> Cold sweats often
3 <input type="radio"/> <input type="radio"/> <input type="radio"/> "Lump" in throat	10 <input type="radio"/> <input type="radio"/> <input type="radio"/> Extremities cold, clammy	17 <input type="radio"/> <input type="radio"/> <input type="radio"/> Fever easily raised
4 <input type="radio"/> <input type="radio"/> <input type="radio"/> Dry mouth-eyes-nose	11 <input type="radio"/> <input type="radio"/> <input type="radio"/> Strong light irritates	18 <input type="radio"/> <input type="radio"/> <input type="radio"/> Neuralgia-like pains
5 <input type="radio"/> <input type="radio"/> <input type="radio"/> Pulse speeds after meal	12 <input type="radio"/> <input type="radio"/> <input type="radio"/> Urine amount reduced	19 <input type="radio"/> <input type="radio"/> <input type="radio"/> Staring, blinks little
6 <input type="radio"/> <input type="radio"/> <input type="radio"/> Keyed up - fail to calm	13 <input type="radio"/> <input type="radio"/> <input type="radio"/> Heart pounds after retiring	20 <input type="radio"/> <input type="radio"/> <input type="radio"/> Sour stomach often
7 <input type="radio"/> <input type="radio"/> <input type="radio"/> Cut heals slowly	14 <input type="radio"/> <input type="radio"/> <input type="radio"/> "Nervous" stomach	

GROUP TWO

21 <input type="radio"/> <input type="radio"/> <input type="radio"/> Joint stiffness on arising	29 <input type="radio"/> <input type="radio"/> <input type="radio"/> Digestion rapid	37 <input type="radio"/> <input type="radio"/> <input type="radio"/> "Slow starter"
22 <input type="radio"/> <input type="radio"/> <input type="radio"/> Muscle-leg-toe cramps at night	30 <input type="radio"/> <input type="radio"/> <input type="radio"/> Vomiting frequent	38 <input type="radio"/> <input type="radio"/> <input type="radio"/> Get "chilled" infrequently
23 <input type="radio"/> <input type="radio"/> <input type="radio"/> "Butterfly" stomach, cramps	31 <input type="radio"/> <input type="radio"/> <input type="radio"/> Hoarseness frequent	39 <input type="radio"/> <input type="radio"/> <input type="radio"/> Perspire easily
24 <input type="radio"/> <input type="radio"/> <input type="radio"/> Eyes or nose watery	32 <input type="radio"/> <input type="radio"/> <input type="radio"/> Breathing irregular	40 <input type="radio"/> <input type="radio"/> <input type="radio"/> Circulation poor, sensitive to cold
25 <input type="radio"/> <input type="radio"/> <input type="radio"/> Eyes blink often	33 <input type="radio"/> <input type="radio"/> <input type="radio"/> Pulse slow; feels "irregular"	41 <input type="radio"/> <input type="radio"/> <input type="radio"/> Subject to colds, asthma, bronchitis
26 <input type="radio"/> <input type="radio"/> <input type="radio"/> Eyelids swollen, puffy	34 <input type="radio"/> <input type="radio"/> <input type="radio"/> Gagging reflex slow	
27 <input type="radio"/> <input type="radio"/> <input type="radio"/> Indigestion soon after meals	35 <input type="radio"/> <input type="radio"/> <input type="radio"/> Difficulty swallowing	
28 <input type="radio"/> <input type="radio"/> <input type="radio"/> Always seems hungry; feels "lightheaded" often	36 <input type="radio"/> <input type="radio"/> <input type="radio"/> Constipation, diarrhea alternating	

GROUP THREE

42 <input type="radio"/> <input type="radio"/> <input type="radio"/> Eat when nervous	49 <input type="radio"/> <input type="radio"/> <input type="radio"/> Heart palpitates if meals missed or delayed	53 <input type="radio"/> <input type="radio"/> <input type="radio"/> Crave candy or coffee in afternoons
43 <input type="radio"/> <input type="radio"/> <input type="radio"/> Excessive appetite	50 <input type="radio"/> <input type="radio"/> <input type="radio"/> Afternoon headaches	54 <input type="radio"/> <input type="radio"/> <input type="radio"/> Moods of depression - "blues" or melancholy
44 <input type="radio"/> <input type="radio"/> <input type="radio"/> Hungry between meals	51 <input type="radio"/> <input type="radio"/> <input type="radio"/> Overeating sweets upsets	55 <input type="radio"/> <input type="radio"/> <input type="radio"/> Abnormal craving for sweets or snacks
45 <input type="radio"/> <input type="radio"/> <input type="radio"/> Irritable before meals	52 <input type="radio"/> <input type="radio"/> <input type="radio"/> Awaken after few hours sleep - hard to get back to sleep	
46 <input type="radio"/> <input type="radio"/> <input type="radio"/> Get "shaky" if hungry		
47 <input type="radio"/> <input type="radio"/> <input type="radio"/> Fatigue, eating relieves		
48 <input type="radio"/> <input type="radio"/> <input type="radio"/> "Lightheaded" if meals delayed		

GROUP FOUR

56 <input type="radio"/> <input type="radio"/> <input type="radio"/> Hands and feet go to sleep easily, numbness	63 <input type="radio"/> <input type="radio"/> <input type="radio"/> Get "drowsy" often	68 <input type="radio"/> <input type="radio"/> <input type="radio"/> Bruise easily, "black and blue" spots
57 <input type="radio"/> <input type="radio"/> <input type="radio"/> Sigh frequently, "air hunger"	64 <input type="radio"/> <input type="radio"/> <input type="radio"/> Swollen ankles, worse at night	69 <input type="radio"/> <input type="radio"/> <input type="radio"/> Tendency to anemia
58 <input type="radio"/> <input type="radio"/> <input type="radio"/> Aware of "breathing heavily"	65 <input type="radio"/> <input type="radio"/> <input type="radio"/> Muscle cramps, worse during exercise; get "charley horses"	70 <input type="radio"/> <input type="radio"/> <input type="radio"/> "Nose bleeds" frequent
59 <input type="radio"/> <input type="radio"/> <input type="radio"/> High altitude discomfort	66 <input type="radio"/> <input type="radio"/> <input type="radio"/> Shortness of breath on exertion	71 <input type="radio"/> <input type="radio"/> <input type="radio"/> Noises in head, or "ringing in ears"
60 <input type="radio"/> <input type="radio"/> <input type="radio"/> Opens windows in closed rooms	67 <input type="radio"/> <input type="radio"/> <input type="radio"/> Dull pain in chest or radiating into left arm, worse on exertion	72 <input type="radio"/> <input type="radio"/> <input type="radio"/> Tension under the breastbone, or feeling of "tightness", worse on exertion
61 <input type="radio"/> <input type="radio"/> <input type="radio"/> Susceptible to colds and fevers		
62 <input type="radio"/> <input type="radio"/> <input type="radio"/> Afternoon "yawner"		



SYMPTOM SURVEY FORM - PAGE 2

GROUP FIVE

- | | | |
|--|--|--|
| <p>1 2 3
73 ○○○ Dizziness
74 ○○○ Dry skin
75 ○○○ Burning feet
76 ○○○ Blurred vision
77 ○○○ Itching skin and feet
78 ○○○ Excessive falling hair
79 ○○○ Frequent skin rashes
80 ○○○ Bitter, metallic taste in mouth in mornings
81 ○○○ Bowel movements painful or difficult
82 ○○○ Worrier, feels insecure</p> | <p>1 2 3
83 ○○○ Feeling queasy; headache over
84 ○○○ Greasy foods upset
85 ○○○ Stools light colored
86 ○○○ Skin peels on foot soles
87 ○○○ Pain between shoulder blades
88 ○○○ Use laxatives
89 ○○○ Stools alternate from soft to watery
90 ○○○ History of gallbladder attacks or gallstones</p> | <p>1 2 3
91 ○○○ Sneezing attacks
92 ○○○ Dreaming, nightmare type bad dreams
93 ○○○ Bad breath (halitosis)
94 ○○○ Milk products cause distress
95 ○○○ Sensitive to hot weather
96 ○○○ Burning or itching anus
97 ○○○ Crave sweets</p> |
|--|--|--|

GROUP SIX

- | | | |
|--|---|---|
| <p>1 2 3
98 ○○○ Loss of taste for meat
99 ○○○ Lower bowel gas several hours after eating
100 ○○○ Burning stomach sensations, eating relieves</p> | <p>1 2 3
101 ○○○ Coated tongue
102 ○○○ Pass large amounts of foul-smelling gas
103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.</p> | <p>1 2 3
104 ○○○ Mucous colitis or "irritable bowel"
105 ○○○ Gas shortly after eating
106 ○○○ Stomach "bloating" after eating</p> |
|--|---|---|

GROUP SEVEN

- | | | |
|--|--|--|
| <p>(A)
1 2 3
107 ○○○ Insomnia
108 ○○○ Nervousness
109 ○○○ Can't gain weight
110 ○○○ Intolerance to heat
111 ○○○ Highly emotional
112 ○○○ Flush easily
113 ○○○ Night sweats
114 ○○○ Thin, moist skin
115 ○○○ Inward trembling
116 ○○○ Heart palpitates
117 ○○○ Increased appetite without weight gain
118 ○○○ Pulse fast at rest
119 ○○○ Eyelids and face twitch
120 ○○○ Irritable and restless
121 ○○○ Can't work under pressure</p> | <p>(C)
1 2 3
137 ○○○ Failing memory
138 ○○○ Low blood pressure
139 ○○○ Increased sex drive
140 ○○○ Headaches, "splitting or rending" type
141 ○○○ Decreased sugar tolerance</p> | <p>(E)
1 2 3
150 ○○○ Dizziness
151 ○○○ Headaches
152 ○○○ Hot flashes
153 ○○○ Increased blood pressure
154 ○○○ Hair growth on face or body (female)
155 ○○○ Sugar in urine (not diabetes)
156 ○○○ Masculine tendencies (female)</p> |
| <p>(B)
1 2 3
122 ○○○ Increase in weight
123 ○○○ Decrease in appetite
124 ○○○ Fatigue easily
125 ○○○ Ringing in ears
126 ○○○ Sleepy during day
127 ○○○ Sensitive to cold
128 ○○○ Dry or scaly skin
129 ○○○ Constipation
130 ○○○ Mental sluggishness
131 ○○○ Hair coarse, falls out
132 ○○○ Headaches upon arising, wear off during day
133 ○○○ Slow pulse, below 65
134 ○○○ Frequency of urination
135 ○○○ Impaired hearing
136 ○○○ Reduced initiative</p> | <p>(D)
1 2 3
142 ○○○ Abnormal thirst
143 ○○○ Bloating of abdomen
144 ○○○ Weight gain around hips or waist
145 ○○○ Sex drive reduced or lacking
146 ○○○ Tendency to ulcers, colitis
147 ○○○ Increased sugar tolerance
148 ○○○ Women: menstrual disorders
149 ○○○ Young girls: lack of menstrual function</p> | <p>(F)
1 2 3
157 ○○○ Weakness, dizziness
158 ○○○ Chronic fatigue
159 ○○○ Low blood pressure
160 ○○○ Nails weak, ridged
161 ○○○ Tendency to hives
162 ○○○ Arthritic tendencies
163 ○○○ Perspiration increase
164 ○○○ Bowel disorders
165 ○○○ Poor circulation
166 ○○○ Swollen ankles
167 ○○○ Crave salt
168 ○○○ Brown spots or bronzing of skin
169 ○○○ Allergies - tendency to asthma
170 ○○○ Weakness after colds, influenza
171 ○○○ Exhaustion - muscular and nervous
172 ○○○ Respiratory disorders</p> |



SYMPTOM SURVEY FORM - PAGE 3

GROUP EIGHT

1 2 3 173○○○ Apprehension	1 2 3 183○○○ Noise sensitivity	1 2 3 193○○○ Insomnia
174○○○ Irritability	184○○○ Acoustic hallucinations	194○○○ Anxiety
175○○○ Morbid fears	185○○○ Tendency to cry without reason	195○○○ Anorexia
176○○○ Never seems to get well	186○○○ Hair is coarse and/or thinning	196○○○ Inability to concentrate; confusion
177○○○ Forgetfulness	187○○○ Weakness	197○○○ Frequent stuffy nose; sinus infections
178○○○ Indigestion	188○○○ Fatigue	198○○○ Allergy to some foods
179○○○ Poor appetite	190○○○ Tendency toward hives	199○○○ Loose joints
180○○○ Craving for sweets	191○○○ Nervousness	
181○○○ Muscular soreness	192○○○ Headache	
182○○○ Depression; feelings of dread		

FEMALE ONLY

1 2 3 200○○○ Very easily fatigued	1 2 3 206○○○ Menstruate too frequently
201○○○ Premenstrual tension	207○○○ Vaginal discharge
202○○○ Painful menses	208○○○ Hysterectomy/ovaries removed
203○○○ Depressed feelings before menstruation	209○○○ Menopausal hot flashes
204○○○ Menstruation excessive and prolonged	210○○○ Menses scanty or missed
205○○○ Painful breasts	211○○○ Acne, worse at menses
	212○○○ Depression of long standing

MALE ONLY

1 2 3 213○○○ Prostate trouble
214○○○ Urination difficult or dribbling
215○○○ Night urination frequent
216○○○ Depression
217○○○ Pain on inside of legs or heels
218○○○ Feeling of incomplete bowel evacuation
219○○○ Lack of energy
220○○○ Migrating aches and pains
221○○○ Tire too easily
222○○○ Avoids activity
223○○○ Leg nervousness at night
224○○○ Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

- 1.
- 2.
- 3.
- 4.
- 5.

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month

FEMALES HAVING MENSTRAUL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row

MALES
Any 2 days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____
Date _____	Temperature _____



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Authorizations

Most patients that come into our office have one or two objectives in mind concerning their health care. Some patients come in for symptomatic relief of pain or discomfort (Relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective care). Your Doctor will weigh your needs and desires when recommending your treatment plan.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care Corrective Care

Patient Signature: _____ Date: _____

I understand and agree that health and accident insurance plans are an arrangement between an insurance carrier and me. Furthermore, I understand that Back To Health Family Chiropractic will prepare any necessary forms and reports to assist me in making collections from my insurance company and that any amount authorized to be paid directly to Back To Health Family Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I terminate or suspend services, all fees for professional services rendered me are immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and that the x-ray negatives will remain the property of Back To Health Family Chiropractic, being on file where they may be seen at any time while a patient of this office.

Patient Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's
Signature of Authorizing Care: _____ Date: _____



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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

Vertebral subluxation: A misalignment of one or more of the 24 vertebra 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.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxation complex and/or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

I understand I can speak with the chiropractor regarding the doctor's objective pertaining to my care in this office. Therefore, I accept chiropractic care on this basis.

(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent 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.

(Signature) (Date)

ALL FEMALES - Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

(Signature) (Date)



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E-Mail Authorization

I would like to share my e-mail address with Back To Health Family Chiropractic for the following uses:

- Contact me regarding schedule changes
- Re-schedule missed appointments
- Inform me of upcoming events in the clinic which may affect me
- Send me a monthly newsletter
- Provide special offers that are available to patients

My e-mail address as with any of my private information is not to be used or shared in any manner that is prohibited by HIPPA laws or inconsistent with the Notice of Privacy Practices which has been made available to me by Back To Health Family Chiropractic.

Patient Name

E-mail Address

(Signature)

(Date)



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INSURANCE STATEMENT

Our clinic does not accept insurance payment for services.

If you have insurance that covers chiropractic, you will be able to submit claims and get reimbursed. The insurance company will send the check directly to you.

Here's how:

Submitting claims to your insurance company is typically a simple procedure.

1. If you plan on filing a claim to be reimbursed by your insurance, let us know. At the end of the week we will print out your receipt which has the information that your insurance company needs.
2. Contact your insurance company to obtain the form you need to fill out. This is separate from the receipt that you will receive from the clinic.
3. Fill in the form from the insurance company. Make copies of this form as well as your receipts to keep for your records.
4. Mail the form and receipt to the address the insurance company gives you.

If you have any questions, please feel free to ask us at any time. We will help you as much as we can.

Received by: _____ Date: _____



Back to Health
Family Chiropractic

CARE FOR A BETTER LIFE

CHRISTOPHER MICHLIN, D.C., B.C.A.O.
NANCY L.B. MICHLIN, M.ED.
6324 CAMP BOWIE BOULEVARD
FORT WORTH, TEXAS 76116
817.810.9111

ACKNOWLEDGEMENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Back To Health Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Back To Health Family Chiropractic's Notice of Privacy Practices prior to signing this document. Back To Health Family Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Back To Health Family Chiropractic. The Notice of Privacy Practices for Back To Health Family Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and Back To Health Family Chiropractic's duties with respect to my protected health information.

Back To Health Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for on at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Name of Privacy Officer: Nancy L. Baskin Michlin, M.Ed.