

BACK TO HEALTH CHIROPRACTIC

Confidential Patient Information Form

Please return completed form to the front desk and have your Drivers License and Insurance Card available.

Is This a Work or Auto Accident injury?

If yes please return this to the front desk for the correct paperwork.

PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Work phone: _____ Cell phone: _____
Email Address: _____
Date of Birth: _____ Gender: Male Female SSN: _____
Marital Status: _____ # of Children: _____
Primary Care Physician: _____ Phone: _____
Education (Highest Level): Elementary School High School College Graduate Degree
Spouse's Name: _____ Date of Birth: _____
Emergency Contact: _____ Phone: _____ Relation: _____
May we ask how you were referred? _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Status: Full Time Part Time
Spouse's Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Status: Full Time Part Time

INSURANCE INFORMATION

Insurance: _____ Type of Insurance Plan: PPO HMO EPO OTHER
Insurance Company Phone Number: _____
Name of Insured: _____ Date of Birth: _____
Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____

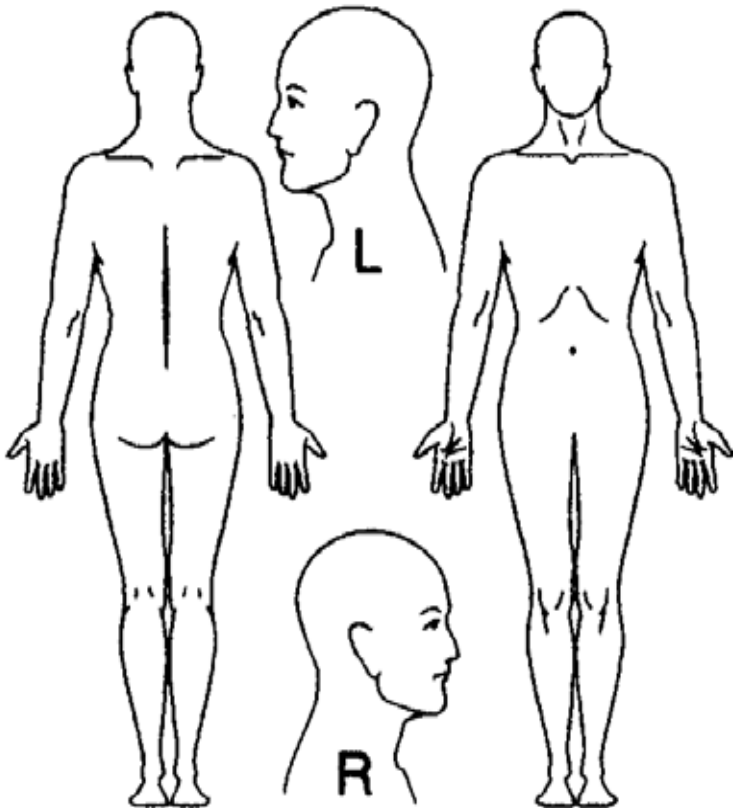
INJURY / ILLNESS INFORMATION (CAUSATION)

When did your pain begin? _____ Type of onset Sudden Over a period of time
 What caused your pain? Unknown Home Injury Auto Accident School Injury Other
 Describe what you believe caused your condition: _____

What helps the pain? _____
 What aggravates the pain? _____
 Have you had this problem before? Never Once More than once How many times? ____
 Is your pain getting: Better Worse Same
 Does the pain disturb your sleep? Yes No

PAIN IDENTIFICATION

Area	How Intense Is The Pain (mark an X on the line)			How Frequent Is The Pain?			
	Low	Moderate	Severe	Constant	Daily	Weekly	Monthly
Head	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Back	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrists	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbows	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	0-----0			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Shade in the areas where you hurt

- Use: **XXXXXXXX** for Numbness
- Use: **.....** for Pins & Needles
- Use: **OOOOOO** for Burning
- Use: **VVVVVV** for Aching
- Use: **IIIIIIIIII** for Stabbing pain

MEDICAL HISTORY

PATIENT HEALTH HISTORY

Please indicate Past (P) or Present (PR) ailments

High Blood Pressure	<input type="checkbox"/> P	<input type="checkbox"/> PR	Irritability	<input type="checkbox"/> P	<input type="checkbox"/> PR	
High Cholesterol	<input type="checkbox"/> P	<input type="checkbox"/> PR	Excess Perspiration	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Diabetes	<input type="checkbox"/> P	<input type="checkbox"/> PR	Extreme Fatigue	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Stomach Pain	<input type="checkbox"/> P	<input type="checkbox"/> PR	Runny Nose	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Heart Murmur	<input type="checkbox"/> P	<input type="checkbox"/> PR	Sore Throat	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Poor Circulation	<input type="checkbox"/> P	<input type="checkbox"/> PR	Chronic Bronchitis	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Chest Congestion	<input type="checkbox"/> P	<input type="checkbox"/> PR	Chest pain	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Depression	<input type="checkbox"/> P	<input type="checkbox"/> PR	Stomach Ulcers	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Stroke	<input type="checkbox"/> P	<input type="checkbox"/> PR	Nausea / Vomiting	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Dizziness	<input type="checkbox"/> P	<input type="checkbox"/> PR	Frequent Heart Burn	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Osteoporosis	<input type="checkbox"/> P	<input type="checkbox"/> PR	Frequent Constipation	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Cancer	<input type="checkbox"/> P	<input type="checkbox"/> PR	Frequent Diarrhea	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Inflammatory Arthritis	<input type="checkbox"/> P	<input type="checkbox"/> PR	Other _____	<input type="checkbox"/> P	<input type="checkbox"/> PR	
Osteoarthritis	<input type="checkbox"/> P	<input type="checkbox"/> PR	Appendectomy	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Asthma	<input type="checkbox"/> P	<input type="checkbox"/> PR	Back Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Psoriasis	<input type="checkbox"/> P	<input type="checkbox"/> PR	Female Related Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Ear Infection	<input type="checkbox"/> P	<input type="checkbox"/> PR	Hip Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Low Blood Pressure	<input type="checkbox"/> P	<input type="checkbox"/> PR	Knee Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Obesity	<input type="checkbox"/> P	<input type="checkbox"/> PR	Neck Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
ADD or ADHD	<input type="checkbox"/> P	<input type="checkbox"/> PR	Open Heart Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Bipolar Disorder	<input type="checkbox"/> P	<input type="checkbox"/> PR	Shoulder Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Prostatitis	<input type="checkbox"/> P	<input type="checkbox"/> PR	Tonsilectomy	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Eye Infection	<input type="checkbox"/> P	<input type="checkbox"/> PR	Craniotomy	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Polio	<input type="checkbox"/> P	<input type="checkbox"/> PR	Gall Bladder Removed	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Insomnia	<input type="checkbox"/> P	<input type="checkbox"/> PR	Ankle Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
Kidney or UTI Infection	<input type="checkbox"/> P	<input type="checkbox"/> PR	Carpal Tunnel Surgery	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____
			Other _____	<input type="checkbox"/> P	<input type="checkbox"/> PR	Date _____

Family History

High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inflammatory Arthritic Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unknown Due to Adoption	<input type="checkbox"/> Yes	

What medications are you currently taking? _____

Do you have any allergies? _____

Have you seen any other health professional for this problem? Yes No

If Yes, Please ask the front desk for a records release form so that we may obtain them.

What treatment prescribed? Adjustment Electric Stimulation Ultrasound Heat
 Ice Exercise Pain Medication Injection Surgery

How much did it help? (no improvement) 1-----10 (full improvement)

Are you being treated currently for any other health problem, serious illness / trauma, chronic or life time condition, or any other ailments? Yes No

If Yes, Please indicate: _____

SOCIAL HISTORY

Do you exercise? Never Rarely Occasionally Regularly Have an active lifestyle
 Regularly prior to this injury

Please explain your exercise program: _____

Do you smoke? Never Previously but don't smoke now Smokes _____ per day
 Chew tobacco

Do you drink alcohol? Never Rarely Occasionally Moderately Excessively
 Drink a few beers on the weekend drank previously but don't drink now

WOMEN ONLY

Is there any possibility that you may be pregnant? Yes No

If Yes, How far along are you? _____

If No, What birth control method? Abstinence Birth control pills (please list in medication area)
 DEPO Shot Contraceptives Condoms

Date of Last Menstrual Period: _____

Do you have or have had any menstrual disorders? Yes No

If Yes, Please indicate: _____

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 also understand that providing incorrect information can be dangerous to my health.

Patient / Guarantor's signature

Date