Back to Health Chiropractic

PATIENT NAME:_____

DATE:_____

NUMBER:_____

◊ New Patient

Welcome To Our Office!

Name_____ Preferred

Name_____

Address_____

_____

City/State/Zip_____

___

Phone #'s

(home)_____(cell)_____

Is it okay to contact you at work? ■ No ■ Yes Work #_____

E-mail Address_____

SSN_____ Birth date_____ Age_____

Occupation_____ Employer _____

Marital Status ■ Single ■ Married ■ Separated ■ Divorced ■ Widowed

Spouse's Name _____ Phone

#_____

Children's names and ages_____

Emergency Contact: Name _____

Relationship_____ Phone #

(s)_____

WHAT BRINGS YOU HERE?

Have you ever had chiropractic care before? ■ No ■ Yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? ■ No ■ Yes

How did you hear about our office? _____

Is this appointment related to: ■ Work ■ Sports ■ Auto

■ Personal Injury ■ Other _____

When did the incident occur? _____

Are you receiving care from other health professionals? ■ No ■ Yes

If yes, please name them and their specialty _____

Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homeopathics/other you are taking _____

What do you know about chiropractic?

In your own words, what do chiropractors do?

Do you know what spinal nerve stress/subluxation is? ☐ No ☐ Yes

If yes, please describe

Do any friends or relatives see chiropractors? ☐ No ☐ Yes

If yes, do they use chiropractic for ☐ health maintenance/optimization

☐ health problems ☐ both

Are you seeking chiropractic for ☐ health maintenance/optimization

☐ health problems ☐ both

What would you like to gain from chiropractic care? _____

Are there other health concerns or anything else you'd like us to know about you? ☐ No ☐ Yes

If yes, please tell us

_____

_____

_____

Financial responsibility

Who is responsible for payment?

_____

How will you pay for your care? ■ Cash ■Check

■ Credit card

#_____Exp:_____

Insurance

Co._____

Insured's

Name_____

Relationship_____ Insured's employer

The above is accurate to the best of my knowledge

_____

_____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____

_____

(signature) (date)

Health history

Do you have, or have you had, any of the following (*please check all the apply)*

■ pneumonia ■ mumps ■ influenza ■ rheumatic fever ■ small pox

■ pleurisy ■ polio ■ chickenpox ■ thyroid disease ■ diabetes

■ Epilepsy ■ cancer ■depression ■ whooping cough ■ anemia

■ eczema ■ measles ■arthritis ■ heart disease ■ rashes

If you have ever been diagnosed with another disease or condition, please describe _____

_____

_____

Do you use ■ coffee ■ tea ■ artificial sweeteners ■ sugar

■ alcohol ■ cigarettes ■recreational drugs

Have you ever suffered from (*please check all the apply)*

■ neck pain ■ stuffy nose ■ discolored urine

■ low back pain ■ allergies ■ gas/bloating after meals

- ☐ headache
- ☐ migraines
- ☐ arm back/tingling
- ☐ shoulder pain
- ☐ hand pain/tingling
- ☐ leg pain/tingling
- ☐ jaw pain
- ☐ chest pain
- ☐ lung problems
- ☐ heart problems
- ☐ abnormal blood pressure
- ☐ irregular heartbeat
- ☐ ankle swelling
- ☐ cold extremities
- ☐ blurred vision
- ☐ vision problems
- ☐ difficulty breathing
- ☐ fainting
- ☐ weight loss
- ☐ poor appetite
- ☐ excessive appetite
- ☐ nervousness
- ☐ confusion
- ☐ depression
- ☐ dental problems
- ☐ excessive thirst
- ☐ frequent thirst
- ☐ vomiting
- ☐ prostate problem
- ☐ breast pain/lump
- ☐ cramps
- ☐ painful urination
- ☐ bladder trouble
- ☐ excessive urination
- ☐ heartburn
- ☐ colitis
- ☐ irritable bowel
- ☐ black or bloody stools
- ☐ constipation
- ☐ hemorrhoids
- ☐ liver problems
- ☐ stroke
- ☐ paralysis
- ☐ tingling
- ☐ numbness
- ☐ fatigue
- ☐ dizziness
- ☐ loss of sleep
- ☐ difficulty hearing
- ☐ ear pain

Past injuries can affect present health (*check all the apply)*

☐ falls/accidents ☐ head injuries ☐ fights ☐ sports injuries ☐ broken bones

☐ dislocations ☐ spinal tap ☐ surgery ☐ traction ☐ extensive dental work

☐ use(d) a cane or walker ☐ dental appliances ☐ knocked unconscious

If yes please describe_____

CURRENT HEALTH

What are your most pressing health concerns?

_____

_____

_____

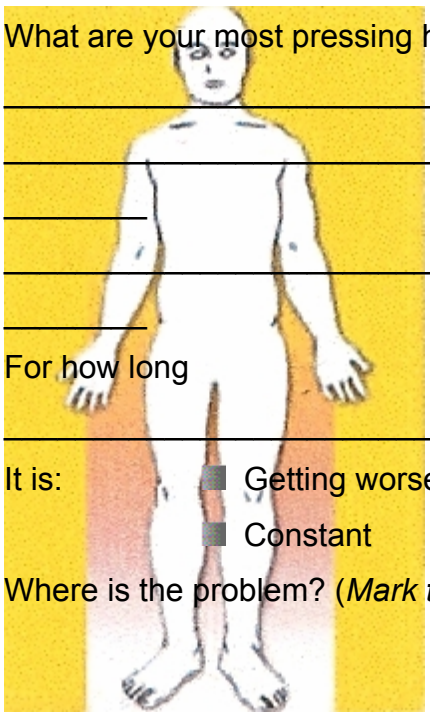
_____

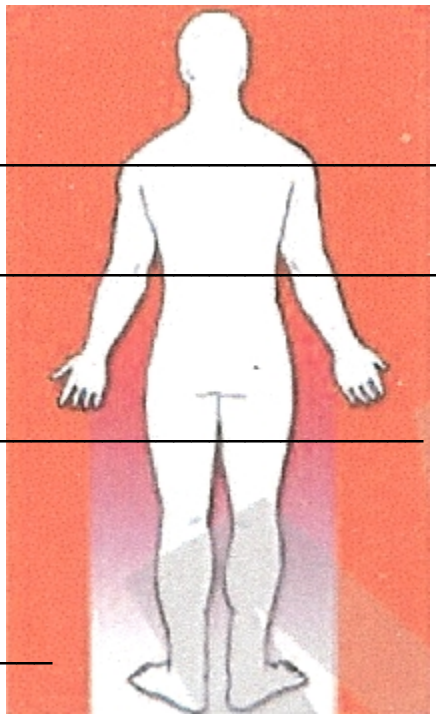
For how long

_____

It is: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Can't Say

Where is the problem? (*Mark the problem areas and explain on lines below)*





Front:_____

_____

_____

_____

_____

_____

Back:_____

_____

_____

_____

_____

_____

Do you have: ■ Pain ■ Numbness ■ Tingling ■ Aches

Is your pain: ■ Sharp ■ Dull ■ Throbbing ■ Constant ■ Intermittent

Are your symptoms ■ Sitting ■ Standing ■ Walking

affected by: ■ Bending ■ Lying down ■ Weather

Please explain:

_____

Do you feel: ■ Cramps ■ Burning ■ Other

■ Swelling ■ Stiffness _____

Do your symptoms ■ Work ■ Sleep ■ Other

Interfere with: ■ Day to day activities ■ Play _____

Please explain

_____

_____

_____

On a scale of 1-10 (1 least, 10 most) please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10