Case #: _____

# Back to Wellness Chiropractic
## PATIENT INFORMATION SHEET

**PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential)**

**PATIENT INFORMATION:**

Last Name: _____ First Name: _____ Today's Date: _____

Patient's Date of Birth: _____ Social Security Number: _____ / _____ / _____

What you prefer to be called: _____ Age: _____ Sex: _____ Drivers License #: _____

Home Address: _____ City_____ Zip Code_____

Home phone #: _____ Work phone #: _____ Cell phone #: _____

E-mail address: _____

Who may we thank for referring you? _____

Employer: _____ How long? _____

Employer's Address: ____ _____

Occupation: _____ Status: Married / Divorced / Single / Widowed

Spouse's Name: _____ Spouse's Occupation: _____

Do you have children? Yes / No How many? _____

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**EMERGENCY:** Contact information for nearest relative or friend.

Who should we contact? _____ Relation: _____

Home phone #: _____ Work phone #: _____ Cell phone #: _____

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**PAYMENT METHOD**: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

---

**INSURANCE:** If you have insurance please give your card to the office manager to be copied.

Insurance Company: _____ Phone: _____

Policy #: _____ Group #: _____ Contract #: _____

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**RESPONSIBLE PARTY:** Complete this section if you are not the patient but are responsible for payment.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____ City_____ Zip Code _____

Home phone #: _____ Work phone #: _____ Cell phone #: _____

Employer Name: _____ Occupation? _____ DOB: _____ SS#: _____/____/_____

Employer's Address: _____ City _____ Zip Code _____

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**REASON for this visit:** _____ Date of injury_____

Work related accident? ☐ **Yes** ☐ **No** Auto Accident? ☐ **Yes** ☐ **No** Other Accident? ☐ **Yes** ☐ **No**

Case #: _____

# Back to Wellness Chiropractic
## PATIENT CASE HISTORY

**ABOUT YOUR HEALTH**
The human body is designed to be healthy. Throughout life events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system and spine that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

**CURRENT PROBLEM**
Chief complaint: _____

Describe the character of your pain: ☐ Sharp/Stabbing ☐ Dull/Ache ☐ Throbbing ☐ Burning ☐ Tingling ☐ Numb ☐ Radiating to _____

How long have you been experiencing the problem? _____ Specific date if possible: _____

How often do you experience the symptom(s)? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Intermittent (26-50%) ☐ Occasional (≤ 25%)

Is your pain: ☐ Increasing ☐ Decreasing ☐ Not Changing

What makes the problem better? _____

What makes the problem worse? _____

Are your complaints affecting your ability to work or activities of daily living? ☐ No effect ☐ Some physical restrictions ☐ Need limited assistance with common everyday tasks ☐ Have a significant inability to function without assistance ☐ Are totally disabled/impaired

This is a ***new / old*** illness. It ***was not / was*** treated before. If treated before, what was done? _____

Name of Doctors: _____

Have you ever had chiropractic care before? ***Yes / No*** If yes, when? _____ Why? _____

**CONFIDENTIAL HEALTH HISTORY**
Weight: _____ lbs. Height: _____ ft. _____in.

Have you ever had surgery or been hospitalized? ***Yes / No*** List Surgeries/Hospitalizations with dates: _____

_____

List any medication(s) you are currently taking: (circle all that apply)

*Pain killers / Anti-inflammatories / Muscle Relaxers / Stimulants / Depressants / Other:*_____

_____

Please list any past serious accidents with dates: _____

Do you have any family history of cardiovascular disease, cancer, or diabetes? (circle all that apply)

**For women only**: Are you pregnant? ***Yes / No*** _____ (Initial)

**WHAT IS YOUR HEALTH PHILOSOPHY?** (What are you currently doing to be healthy?) _____

_____

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

_____ Temporary Relief (Help alleviate the symptom(s) but no permanent correction to the cause of the problem)

_____ Maximum Correction (Correct the cause of the problem for optimal health in the future)

**On a scale of 1 through 10** (10 being the most, 1 being the least), please rank your commitment to the following:

How committed are you at being at your maximum health potential?
1 2 3 4 5 6 7 8 9 10

How committed are you in wanting to get this problem handled once and for all?
1 2 3 4 5 6 7 8 9 10

Case #: _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

**INTAKE**

- ☐ Coffee
- ☐ Soda
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar
- ☐ Artificial Sweeteners

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:**

**MUSCULO-SKELETAL**

- ☐ Neck Pain
- ☐ Pain Between Shoulders
- ☐ Low Back Pain
- ☐ Arm/Leg Pain
- ☐ Joint Pain/Swelling/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

**NERVOUS SYSTEM**

- ☐ Nervousness
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Dizziness/Loss of Balance
- ☐ Forgetfulness/Memory Loss
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions/Tremors
- ☐ Trouble Concentrating
- ☐ Stress

**GENERAL**

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Frequent Colds/Flus
- ☐ Headaches/Migraines
- ☐ Tension/Irritable

**GASTROINTENSTINAL**

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea/Constipation
- ☐ Hemorrhoids
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating
- ☐ Heartburn/Upset Stomach
- ☐ Black/Bloody Stool
- ☐ Colitis

**GENITO-URINARY**

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discharge/Discolored Urine

**C-V-R**

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Heart Attack
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Wheezing

**EENT**

- ☐ Blurred/Double Vision
- ☐ Loss of Smell or Taste
- ☐ Sore Throat
- ☐ Ear Aches/Infections
- ☐ Hearing Difficulty
- ☐ Ringing in Ears

**FEMALES ONLY**

When was your last Period?

_____

Are you trying to get pregnant?

- ☐ Yes
- ☐ No

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps

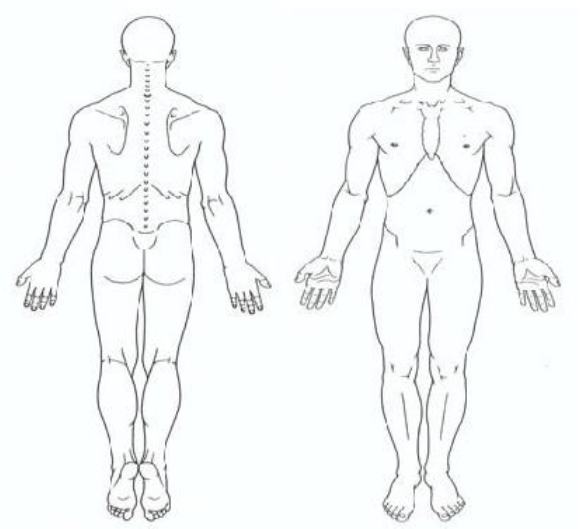
**MALES ONLY**

- ☐ Prostate Sexual Dysfunction
- ☐ Impotence

**OTHER PROBLEMS**

_____

**Please outline on the diagram the area(s) of discomfort**



**FAMILY HISTORY**

The following members have the same or similar problem(s) as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

**ABOUT YOUR CARE**

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statues, to provide me with chiropractic care.

Patient or Guardian Signature: _____ Date: _____