Back 2 Health Chiropractic

PATIENT INFORMATION FORM Today's Date: _____

Full Name: _____ Marital Status: ☐ Single ☐ Married

Birth Date: _____ - _____ - _____ Age: ☐ ☐ _____ Male Female

Address: _____ City:_____ State:_____ Zip:_____

E-mail Address: _____ Driver's License # _____

Phone Number:_____ ☐ Mobile ☐ Home ☐ Work

Preferred Method of contact: ☐ E-mail ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

How did you hear about us: ☐ Search Engine (Google, Bing, etc.) ☐ Social Media ☐ Mailer ☐ Word of Mouth ☐ Referral: _____ ☐ Other: _____

CHIEF COMPLAINT

Please identify the condition(s) that brought you to this office and how they happened:

PRIMARY: _____

SECONDARY: _____

When did chief complaint begin: _____

Rate your pain intensity on a scale from 0 to 10 (with 0 being no pain and 10 being the worst):

Pain RIGHT NOW: no pain 1 2 3 4 5 6 7 8 9 10 worst

Pain is at its WORST: no pain 1 2 3 4 5 6 7 8 9 10 worst

Pain is its LEAST: no pain 1 2 3 4 5 6 7 8 9 10 worst

Pain at MOST times: no pain 1 2 3 4 5 6 7 8 9 10 worst

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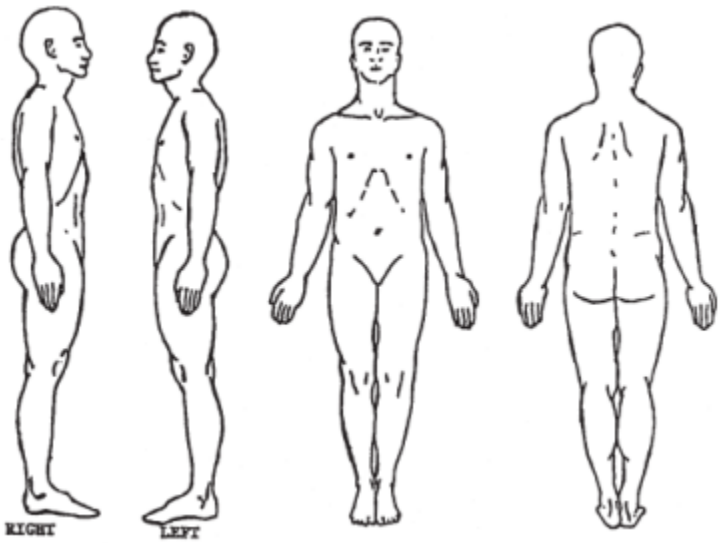
Please mark on this diagram where your pain occurs by shading the painful area(s):



What time of day is your pain at its worst:

☐ Morning ☐ Afternoon ☐ Evening ☐ Night (sleeping hours)

☐ Pain is always the same ☐ Pain varies, but no particular time

How long does your pain last:

☐ Constant (95-100% of the time) ☐ Nearly constantly (60-95% of the time)

☐ Intermittently (30-60% of the time) ☐ Occasionally (Less than 30% of the time)

Check all the words that describe your pain:

☐ Burning ☐ Sharp ☐ Aching ☐ Throbbing

☐ Shooting ☐ Numbness ☐ Tingling ☐ Stiffening

☐ Muscle spasm ☐ Dull ☐ Sore ☐ Stabbing

☐ Tightness ☐ Needles ☐ Spasm ☐ Weak

☐ Other (describe) _____

Does the pain travel anywhere: ☐ Yes ☐ No If yes, where: _____

How do the following affect your pain: (check one for each item)

	Decrease	Increase	No affect
Cold	☐	☐	☐
Heat	☐	☐	☐
Massage	☐	☐	☐
Medication	☐	☐	☐
Reclining	☐	☐	☐
Sitting	☐	☐	☐
Work	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Exercise	☐	☐	☐
Stretching	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Lying down	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐
Running	☐	☐	☐
Other:_____	☐	☐	☐

LIST AFFECTED ACTIVITIES:	CURRENT RESTRICTION LEVEL	YOUR SUCCESS GOAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck?
☐ Yes ☐ No

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back?
☐ Yes ☐ No

Have you ever been adjusted by a chiropractor before: ☐ YES ☐ NO
If yes, when and where was the last time you had a complete spinal exam, including x-rays:

_____

How often did you get adjusted: ☐ 3-4x week ☐ 1-2x week ☐ Only when it hurt

Stress will cause you to accelerate spinal damage. Rate your stress level.
Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

PAST HISTORY

Please identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

Is it a similar problem to chief complaint: ☐ Yes ☐ No

When was the last episode: _____

How did the injury happen: _____

What other types of health care professionals have you seen in connection with your pain?

_____

Length of care: _____ How long ago: _____

What type of treatment: _____

What were the results? Favorable? Unfavorable? please explain: _____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have and N for Never have had:

_____Stroke _____Broken Bone _____Dislocations _____Tumors _____ Fracture
_____Disability _____Cancer _____Heart Attack _____Diabetes _____Osteo Arthritis
_____Rheumatoid Arthritis _____Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any CURRENT conditions you feel may be contributing to your present problems

INJURIES / ACCIDENTS:
SURGERIES:
CHILDHOOD DISEASES:
MEDICATIONS (name/reason/how long for each):

SOCIAL HISTORY

-Smoking: ☐cigars ☐pipe ☐cigarettes: ☐Y ☐N How often? Daily Weekends Occasionally Never

-Alcoholic Beverage: consumption occurs: ☐Y ☐N Daily Weekends Occasionally Never

-Recreational Drug use: Daily Weekends Occasionally Never

FAMILY HISTORY

-Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

-If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister's ☐ Brother's ☐ Son's ☐ daughter's

-Have they ever been treated for their condition? ☐ Yes ☐ No ☐ Don't know

-Any other hereditary conditions the doctor should be aware of ☐ No ☐ Yes: _____

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Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at BACK 2 HEALTH CHIROPRACTIC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____

_____

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

****IF YOU BELIEVE THERE IS A POSSIBILITY YOU MAY BE PREGNANT
PLEASE NOTIFY THE DOCTOR OR STAFF PRIOR TO YOUR **EXAMINATION****

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to myself (and/or my unborn child if female), and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

Patient or Authorized Person's Signature Date

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____

____

Patient or Authorized Person's Signature Date