



**Patient Registration Data**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE #'S: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ POSITION: \_\_\_\_\_

NAME, RELATION, & PHONE # OF PERSON TO NOTIFY IN CASE OF EMERGENCY:

\_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

**INSURANCE INFORMATION**

PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARD(S)

PRIMARY INSURANCE: \_\_\_\_\_ Policy # \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ Policy # \_\_\_\_\_

REFERRING PRIMARY CARE PHYSICIAN: \_\_\_\_\_

**TREATMENT CONSENT**

I hereby request and consent to the performance of Chiropractic Manipulation, Acupuncture, Active Release Technique, Graston Technique and other chiropractic procedures. I understand and I am informed that as in the practice of medicine, with the practice of chiropractic medicine there some risks. These risks may include but are not limited to: fractures, strokes, disc injuries, dislocations and sprains. I do not expect the physician to be able to explain or anticipate all risks and complications, and I choose to rely on the physician to exercise his best judgment during the course of my treatment. This concerns which treatment(s) are in my best interest, based upon the facts as they are known at that time.

Signature Patient (or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

I, the undersigned, have insurance benefits with \_\_\_\_\_ and assign directly to, Back to Health Chiropractic & Acupuncture all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I hereby authorize any holder of medical information about me to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature Patient (or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

# Pain Assessment

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ How did this onset occur?: \_\_\_\_\_

If this is a new injury, how & where did it occur? \_\_\_\_\_

Has anything made your pain worse since your last visit? \_\_\_\_\_

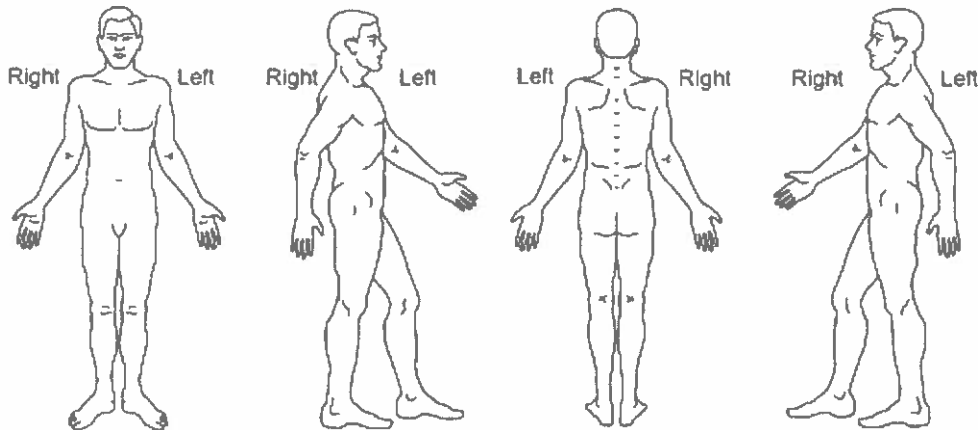
1. Please circle the letter(s) that corresponds with the type(s) of pain you are having:

**A = Ache B = Burning N = Numbness P = Pins & Needles  
S = Stabbing SP = Sharp SR = Sore D= Dull O = Other**

2. Please rate the severity of discomfort by circling the corresponding number on the following scale:

**0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_ 8 \_\_\_\_\_ 9 \_\_\_\_\_ 10**  
**(0= No Pain, 5= Moderate Pain, 10=Severe Pain)**

3. Please mark an X on the picture where you are having pain:



Approximately what amount of your day are you experiencing this discomfort? (please circle one):

$\frac{1}{4}$  day       $\frac{1}{2}$  day       $\frac{3}{4}$  day      Constantly

Does it interfere with your (check all that apply)

Work \_\_\_\_\_, Sleep \_\_\_\_\_, Daily Routine \_\_\_\_\_, Other \_\_\_\_\_

Activities or Movements that aggravate the pain (check all that apply)

Sitting \_\_\_\_\_, Standing \_\_\_\_\_, Walking, Twisting/Turning, \_\_\_\_\_ Bending \_\_\_\_\_, Lying down \_\_\_\_\_

Other \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# CHIROPRACTIC HEALTH QUESTIONNAIRE

Date \_\_\_\_\_

Patient name \_\_\_\_\_ Birthdate \_\_\_\_\_

Reason for visit \_\_\_\_\_

Have you been treated before for this problem?  No  Yes

If yes, by  Physician  Doctor of Chiropractic  Physical Therapist  Osteopath  Other \_\_\_\_\_

What did they do and/or recommend? \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_ Is this condition getting progressively worse?  Yes  No  Unknown

Is it constant or does it come and go? \_\_\_\_\_ Does it interfere with your  Work  Sleep  Daily routine  Recreation

Activities or movements that are painful to perform  Sitting  Walking  Bending  Lying down

Other \_\_\_\_\_

Your Occupation \_\_\_\_\_  
(Describe activities - sitting, lifting, etc.)

Have you ever had chiropractic care for other problems?  No  Yes  When? \_\_\_\_\_

Do you take  Muscle relaxers  Pain killers  Insulin  Birth control pills  Over-the-counter meds

Other prescription drugs \_\_\_\_\_ Please list all medication in the space at bottom of page.

Date of last: Physical exam \_\_\_\_\_ Spinal x-ray \_\_\_\_\_ Blood test \_\_\_\_\_

Spinal exam \_\_\_\_\_ Chest x-ray \_\_\_\_\_ Urine test \_\_\_\_\_

Dental x-ray \_\_\_\_\_ MRI, CT-scan, bone scan \_\_\_\_\_

Sleep \_\_\_\_\_ hrs/night Do you sleep on your  Back  Side  Stomach Non-job exercise \_\_\_\_\_ hrs/wk

Age of mattress \_\_\_\_\_ or waterbed \_\_\_\_\_ Is your bed comfortable?  No  Yes

What kind of pillow do you use?  Thick  Medium  Thin  None  Support

Do you wear  Heel lifts  Shoe lifts  Arch supports  Orthotics, describe \_\_\_\_\_

## CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Fractures	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors, growths
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis	

## MEDICATIONS List medications you are currently taking.

Allergies _____	
Pharmacy Name _____	Phone _____

(OVER)

**GENERAL SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year

<p><b>GENERAL</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight gain <p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p><b>GAS / GINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>EYE, EAR, NOSE, ...ROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - flashes <input type="checkbox"/> Vision - halos <p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>MEN only</b></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other <p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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**NECK, BACK, EXTREMITIES** Check (✓) symptoms you currently have or have had in the past year

<p><b>NECK</b></p> <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding/popping sounds in neck <p><b>SHOULDERS</b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td>    <input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td>    <input type="checkbox"/> Over head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> </table> <p><b>MID-BACK</b></p> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades		Right	Left	<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain across shoulders			<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Above shoulder level			<input type="checkbox"/> Over head			<input type="checkbox"/> Tension in shoulders			<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<p><input type="checkbox"/> Pain from front to back  <input type="checkbox"/> Muscle spasms in mid-back</p> <p><b>ARMS &amp; HANDS</b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in upper arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in elbow</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in forearm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in hand</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in fingers</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pins &amp; 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FEET</b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in buttocks</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in hip joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain down leg</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in knee</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in ankle</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in foot</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Weakness of leg</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Weakness of knee</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Leg cramps</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> </table> <p><b>OTHER SYMPTOMS</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		Right	Left	<input type="checkbox"/> Pain in buttocks	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain in hip joint	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain down leg	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain in knee	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain in ankle	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain in foot	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Weakness of leg	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Weakness of knee	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> R	<input type="checkbox"/> L
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____	Date _____
Reviewed by _____	Date _____
Doctor	

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