Back to Health
Chiropractic & Acupuncture

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? _____

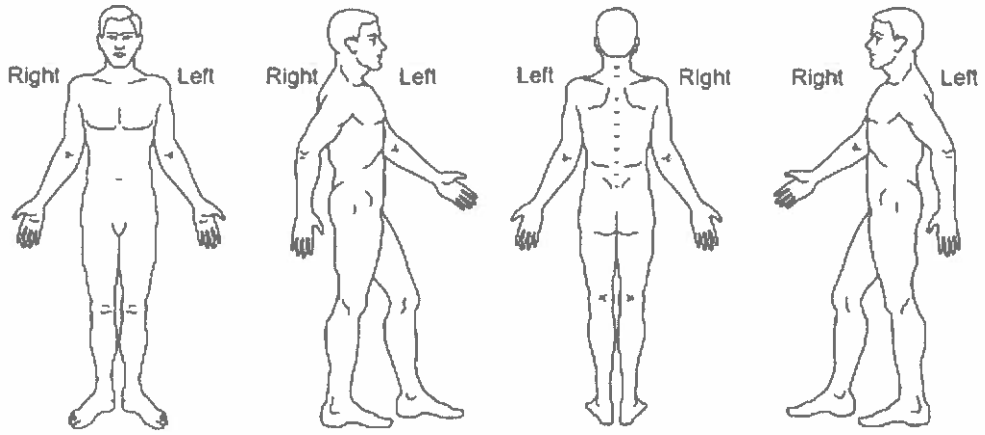
1. Please circle the letter(s) that corresponds with the type(s) of pain you are having:

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):

¼ day ½ day ¾ 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

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

MEDICATIONS List medications you are currently taking

VITAMINS/HERBS/MINERALS

Allergies_____

Pharmacy Name_____ Phone_____

(OVER)

GENERAL SYMPTOMS Check (✓) Symptoms you currently have or have had in the past

GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past years

NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS (Right / Left)
- ☐ Pain in shoulder joint ☐ R ☐ L
- ☐ Pain across shoulders
- ☐ Can't raise arm ☐ R ☐ L
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder ☐ R ☐ L

MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

ARMS & HANDS (Right / Left)
- ☐ Pain in upper arm ☐ R ☐ L
- ☐ Pain in elbow ☐ R ☐ L
- ☐ Pain in forearm ☐ R ☐ L
- ☐ Pain in hand ☐ R ☐ L
- ☐ Pain in fingers ☐ R ☐ L
- ☐ Pins & needles in arm ☐ R ☐ L
- ☐ Pins & needles in fingers ☐ R ☐ L
- ☐ Numbness in arm ☐ R ☐ L
- ☐ Numbness in fingers ☐ R ☐ L
- ☐ Weakness of arm ☐ R ☐ L
- ☐ Weakness of hand ☐ R ☐ L
- ☐ Hands cold ☐ R ☐ L

LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

HIPS, LEGS & FEET (Right / Left)
- ☐ Pain in buttocks ☐ R ☐ L
- ☐ Pain in hip joint ☐ R ☐ L
- ☐ Pain down leg ☐ R ☐ L
- ☐ Pain in knee ☐ R ☐ L
- ☐ Pain in ankle ☐ R ☐ L
- ☐ Pain in foot ☐ R ☐ L
- ☐ Weakness of leg ☐ R ☐ L
- ☐ Weakness of knee ☐ R ☐ L
- ☐ Leg cramps ☐ R ☐ L

OTHER SYMPTOMS

_____

_____

_____

_____

_____

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_____ Doctor

_____ Date

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