BACK TO HEALTH CHIROPRACTIC

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New Patient Contact Form

Name:_____Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

D.O.B.: ___/___/_____ Marital Status: ☐M ☐S ☐W ☐D Patient here before? Y or N

Home Phone:_____ Cell:_____
*This is the number where you will receive text reminders for your appointments

Email:_____

Your Employer:_____ Position:_____ Phone:_____

Your Emergency Contact:_____ Relation:_____ Phone:_____

Reason for your visit today:

☐ Auto Accident ☐Work Accident ☐Injury/Illness ☐Wellness

If you are being treated for an accident/injury, please list the date of your accident/injury: ____/____/_____

Do you have an attorney? Y / N (If yes) Attorney Name:_____

Case Manager:_____ Phone:_____

Do you have health insurance? Y / N (If yes) Insurance Carrier:_____

Policy Holder:_____ Relationship:_____

How did you hear about our office?_____

Have you ever been to a chiropractor before? Y / N (circle) What was the problem:_____

Have you been treated for this particular problem by any other healthcare professionals? Y / N (circle one)
Where? _____ When?_____
Have you received any imaging related to this problem? Y / N Facility name:_____

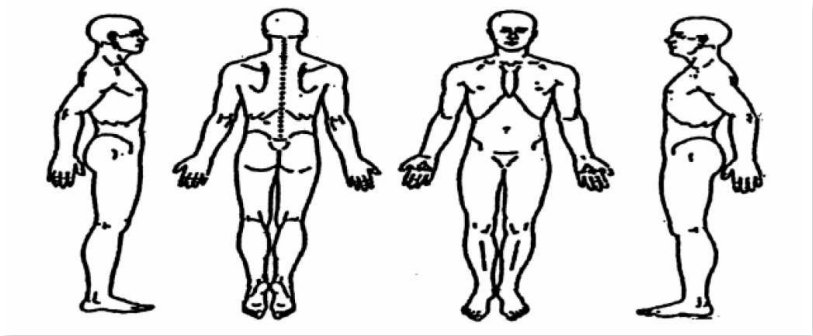
_____Please initial to acknowledge review of Back to Health Chiropractic's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that you have been made aware of your privacy rights.

Back to Health Chiropractic Patient Intake Form

Patient Name: _____Date: ___/___/_____

1. Is today's problem caused by: ▫ Illness/Injury ▫ Auto Accident ▫Slip/Fall

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

▫ Constantly (76-100% of the time) ▫ Occasionally (26-50% of the time)
▫ Frequently (51-75% of the time) ▫ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

▫ Sharp ▫ Numb ▫ Dull ▫ Tingly ▫ Diffuse ▫ Sharp with motion
▫ Achy ▫ Shooting with motion ▫ Burning ▫ Stabbing with motion
▫ Shooting ▫ Electric like with motion ▫ Stiff ▫ Other:_____

5. How are your symptoms changing with time?

▫ Getting Worse ▫ Staying the Same ▫ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

▫ Not at all ▫ A little bit ▫ Moderately ▫ Quite a bit ▫ Extremely

8. How much has the problem interfered with your social activities?

▫ Not at all ▫ A little bit ▫ Moderately Quite a bit ▫ Extremely

9. Who else have you seen for your problem?

▫ Chiropractor ▫ Neurologist ▫ Primary Care Physician
▫ ER physician ▫ Orthopedist ▫ Other:_____
▫ Massage Therapist ▫ Physical Therapist ▫ No one

10. How long have you had this problem?

_____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

▫ Yes ▫ Yes, at times ▫ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height ____'___" Weight _____ lbs. Date of Birth ____/____/_____

Occupation _____

16. How would you rate your overall Health?

▫ Excellent ▫ Very Good ▫ Good ▫ Fair ▫ Poor

17. Indicate if you have any immediate family members with any of the following:

▫ Rheumatoid Arthritis ▫ Diabetes ▫ Lupus

▫ Heart Problems ▫ Cancer ▫ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
▫	▫ Headaches	▫	▫ Diabetes	▫	▫ High Blood Pressure
▫	▫ Neck Pain	▫	▫ Heart Attack	▫	▫ Excessive Thirst
▫	▫ Upper Back Pain	▫	▫ Chest Pains	▫	▫ Frequent Urination
▫	▫ Mid Back Pain	▫	▫ Stroke	▫	▫ Smoking/Tobacco
▫	▫ Low Back Pain	▫	▫ Angina	▫	▫ Drug/Alcohol Dependance
▫	▫ Shoulder Pain	▫	▫ Kidney Stones	▫	▫ Allergies
▫	▫ Kidney Disorders	▫	▫ Depression	▫	▫ Elbow/Upper Arm Pain
▫	▫ Wrist Pain	▫	▫ Bladder Infection	▫	▫ Systemic Lupus
▫	▫ Hand Pain	▫	▫ Painful Urination	▫	▫ Epilepsy
▫	▫ Hip Pain	▫	▫ Dermatitis/Eczema	▫	▫ Loss of Bladder Control
▫	▫ Upper Leg Pain	▫	▫ Prostate Problems	▫	▫ HIV/AIDS
▫	▫ Knee Pain	▫	▫ Ankle/Foot Pain	▫	▫ Loss of Appetite
					For Females Only
▫	▫ Jaw Pain	▫	▫ Abdominal Pain	▫	▫ Birth Control Pills
▫	▫ Joint Pain/Stiffness	▫	▫ Ulcer	▫	▫ Hormonal Replacement
▫	▫ Arthritis	▫	▫ Hepatitis	▫	▫ Pregnancy
▫	▫ Rheumatoid Arthritis	▫	▫ Liver/Gall Bladder Disorder		
▫	▫ Cancer	▫	▫ General Fatigue		
▫	▫ Tumor	▫	▫ Muscular Incoordination		
▫	▫ Asthma	▫	▫ Visual Disturbances		
▫	▫ Chronic Sinusitis	▫	▫ Dizziness		
▫	▫ Abnormal Weight Gain/Loss	▫	▫ Other:_____		

20. List all prescription medications you are currently taking for this condition:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

▫ **Sit:** ▫ *Most of the day* ▫ *Half the day* ▫ *A little of the day*

▫ **Stand:** ▫ *Most of the day* ▫ *Half the day* ▫ *A little of the day*

▫ **Computer work:**
▫ *Most of the day* ▫ *Half the day* ▫ *A little of the day*

▫ **On the phone:**
▫ *Most of the day* ▫ *Half of the day* ▫ *A little of the day*

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ▫ No ▫ Yes

if yes, why and when?

_____

26. Have you had significant past trauma? ▫ No ▫ Yes

27. Anything else pertinent to your visit today?

_____

_____

Patient Signature_____Date:_____

BACK TO HEALTH
CHIROPRACTIC

NON-ACCIDENT/ NON-INJURY STATEMENT

Patient Name: _____ **Date**: _____

This letter shall serve as notice that my care at Back to Health Chiropractic is *not* due to an automobile accident, work related injury, or any other type of accident.

Patient Signature: _____

Witness: _____