

We appreciate the opportunity to help you get back to the health. The more accurate and complete the information you give us, the better service we can give you.

Date: _____ Patient # _____ (assigned by office)

Full Name: _____ Social Security # _____

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

E-mail address: _____ Home Phone _____ Cell Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D How many children? _____

Height: _____ Weight: _____ Occupation: _____ Office Phone: _____

Employer: _____ Address: _____

Spouse: _____ Occupation: _____ Employer: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

Family Medical Doctor: _____ How were you referred to our office? _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint and/or Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____ Is this due to: Auto _____ Work _____

Describe the injury/accident _____

Have you ever had the same or a similar condition? _____ If yes, when and describe: _____

Other doctors you have consulted for this condition: _____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Emotional Difficulty	<input type="checkbox"/> Thyroid Trouble
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dislocated Joints	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Prostate Trouble	<input type="checkbox"/> Polio
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> STDs
<input type="checkbox"/> Bone Fracture	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Sinus Trouble	
<input type="checkbox"/> Cirrhosis/Hepatitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spinal Disc Disease	Other _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No

If yes, describe: _____

Do you have any allergies of any kind? Yes No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Lifting _____ sitting _____ bending _____ working at a computer _____

FAMILY HISTORY:

Father: Current age if still living: _____ Cause of death and age at death if deceased: _____

Mother: Current age if still living: _____ Cause of death and age at death if deceased: _____

Do you have any family members who suffer from the same condition you do? If so, please list: _____

FAMILY DISEASES (check if applicable and indicate whether family member is Father, Mother, Sister, Brother):

Tuberculosis _____	Cancer _____	Mental Illness _____
Diabetes _____	Asthma _____	Heart Disease _____
Stroke _____	Kidney Disease _____	Lung Disease _____
Arthritis _____	Liver Disease _____	
Other _____		

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical ___ Worker's Compensation ___ Medicaid ___ Medicare ___ Auto Accident
___ Medical Savings Account & Flex Plans ___ Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

FIRST Area of Concern: _____

Severity: Mild Moderate Severe

Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10 (Excruciating)

Frequency: Intermittent Occasional Frequent Constant

When did you first notice the pain: _____

How did it occur: _____

What makes it better: Sit Stand Lay Down Nothing

What makes it worse: Sit Stand Bend Lift Cough Sneeze Walk

Describe the pain: Ache Dull Sharp Stabbing Burning Throbbing

Does the pain radiate: Head Neck Hip Leg Shoulders Arms Hands Buttocks

Timing: Morning Afternoon Evening Night With Activity

Side Effects: Numbness Tingling Weakness Stiffness Burning

Women Only: Are you pregnant or is there any possibility you may be pregnant?

Yes No Uncertain

Recent Diagnostic testing-List area evaluated, date, where performed:

X-rays _____ MRI _____

Other _____

**If there are additional areas of concern, please complete the reverse side.*

Patient's Signature _____ Date _____

SECOND Area of Concern: _____

Severity: Mild Moderate Severe

Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10 (Excruciating)

Frequency: Intermittent Occasional Frequent Constant

When did you first notice the pain: _____

How did it occur: _____

What makes it better: Sit Stand Lay Down Nothing

What makes it worse: Sit Stand Bend Lift Cough Sneeze Walk

Describe the pain: Ache Dull Sharp Stabbing Burning Throbbing

Does the pain radiate: Head Neck Hip Leg Shoulders Arms Hands Buttocks

Timing: Morning Afternoon Evening Night With Activity

Side Effects: Numbness Tingling Weakness Stiffness Burning

THIRD Area of Concern: _____

Severity: Mild Moderate Severe

Pain Intensity: 0 1 2 3 4 5 6 7 8 9 10 (Excruciating)

Frequency: Intermittent Occasional Frequent Constant

When did you first notice the pain: _____

How did it occur: _____

What makes it better: Sit Stand Lay Down Nothing

What makes it worse: Sit Stand Bend Lift Cough Sneeze Walk

Describe the pain: Ache Dull Sharp Stabbing Burning Throbbing

Does the pain radiate: Head Neck Hip Leg Shoulders Arms Hands Buttocks

Timing: Morning Afternoon Evening Night With Activity

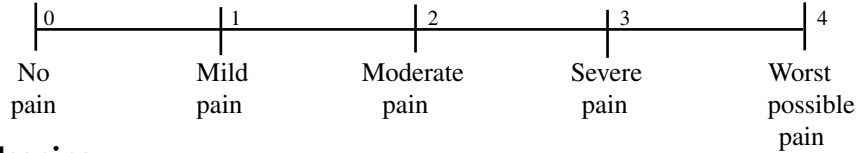
Side Effects: Numbness Tingling Weakness Stiffness Burning

Functional Rating Index

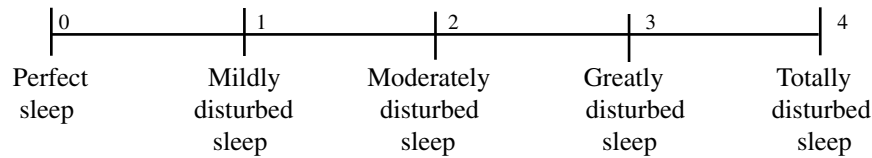
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

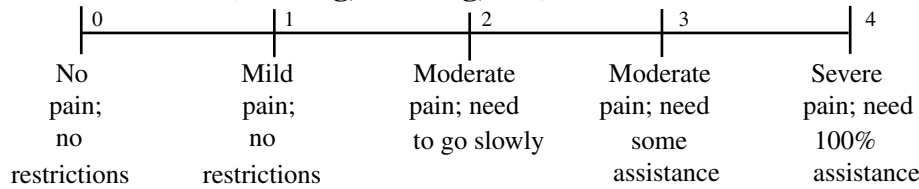
1. Pain Intensity



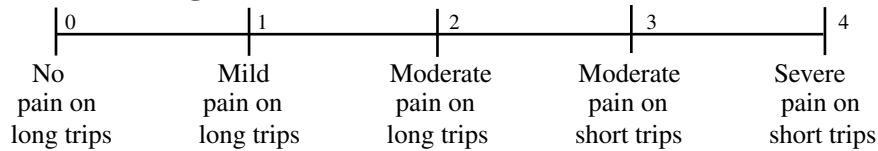
2. Sleeping



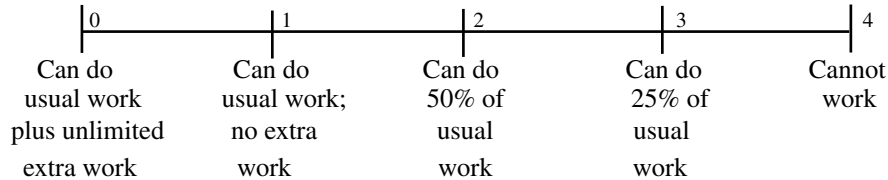
3. Personal Care (washing, dressing, etc.)



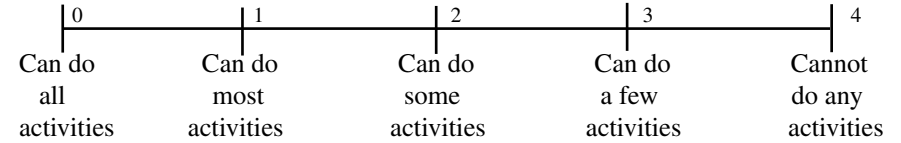
4. Travel (driving, etc.)



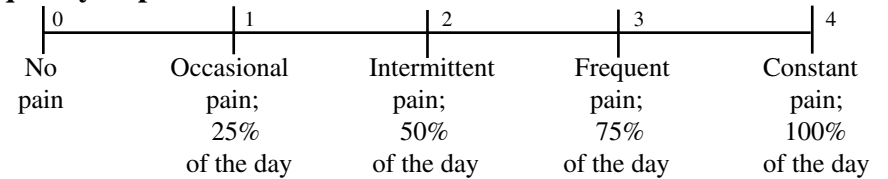
5. Work



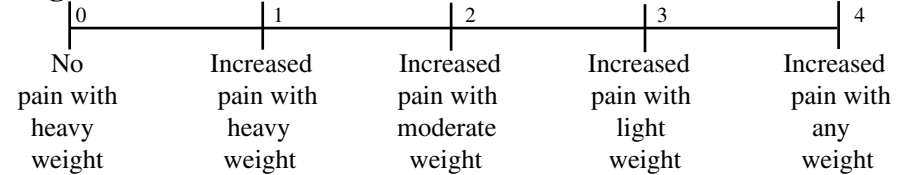
6. Recreation



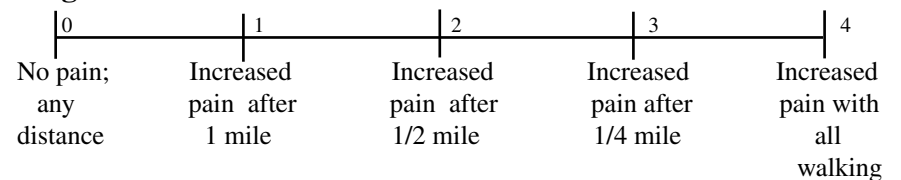
7. Frequency of pain



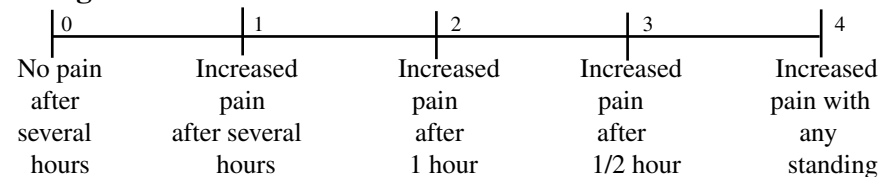
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent
for Use of Health Information**

Name _____

Date _____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of **Back2Health's** Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this **Back2Health's** HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20____

By _____

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____

Signature of Parent/Guardian (circle one)