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)

__Aids/HIV	__Diabetes	__Mental Emotional Difficulty	__Thyroid Trouble
__Allergies	__Dislocated Joints	__Multiple Sclerosis	__Tuberculosis
__Anemia	__Diverticulitis	__Pacemaker	__Ulcer
__Arthritis	__Hay Fever	__Prostate Trouble	__Polio
__Asthma	__Cardiovascular Disease	__Rheumatic Fever	__STDs
__Bone Fracture	__High Blood Pressure	__Scoliosis	__Epilepsy
__Cancer	__Kidney Trouble	__Sinus Trouble	
__Cirrhosis/Hepatitis	__Low Blood Pressure	__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 **F**ather, **M**other, **S**ister, **B**rother):

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:_____

<u>FIRST</u> 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 _____

<u>SECOND</u> 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

<u>THIRD</u> 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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any 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 Noti**c**e 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)