Confidential Patient Information

Back to Health Chiropractic
2317 E. Lincolnway, Suite D
Sterling, Illinois 61081
(815) 625-5400 Phone
(815) 626-5419 Fax
www.Back2HealthChiropractic.com

Date:_____/_____/_____

Patient's Full Name: _____

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

Cell Phone:_____-_____-_____ Additional Phone:_____-_____-_____ E-Mail:_____

☐ Male ☐ Female Date of Birth:_____/_____/_____

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:_____ Number of Children/Ages _____

Currently Pregnant ☐ Yes _____weeks ☐ No #of Vaginal births:_____ # of Cesarean births:_____

How did you find us?

- Existing Patient
  Name:_____
- Physician
  Name:_____
- Friend
  Name:_____
- BIRTHFIT
- Google
- Social Media
- Office Website
- ICPA Website
- Other Website:_____
- Other _____

Social Security # _____-_____-_____

Status ☐ Employed ☐ Full-time Student ☐ Part-time Student ☐ Retired ☐ Unemployed
Occupation:_____
Employer:_____

Emergency Contact:_____ Relationship:_____ Phone:_____-_____-_____

Family Physician:_____ City:_____ State:_____ Phone:_____-_____-_____

Previous Chiropractic Care ☐ Yes ☐ No If Yes, for what problem:_____

Chiropractor's Name/Location:_____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.
2. I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Patient Signature:_____ Date:_____/_____/_____

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Dear Patient: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Present complaint(s):_____

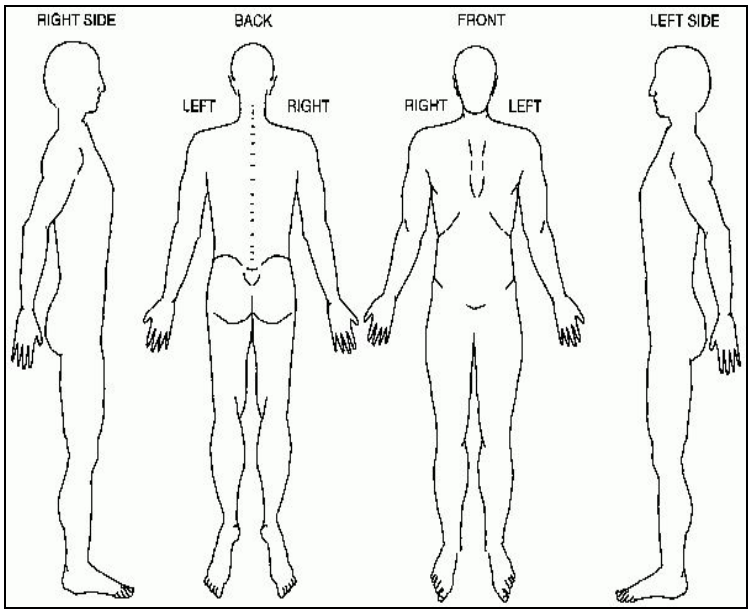
When did your symptoms begin? (Specific date if possible)_____

How did you symptoms begin? (i.e. lifting, etc)_____

In the past have you had anything similar to this? ☐Yes ☐No Please explain_____

Please fill out the pain chart below, or select one of the following reasons for your visit:

☐ Pregnancy ☐ Diastasis Rectus Abdominis ☐ Pelvic Floor Dysfunction ☐ Wellness



DESCRIBE YOUR PAIN

#1 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain **Unbearable**

Check all that apply to your #1 Complaint:

☐ Sharp	☐ Ache	☐ Tingling
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ **Other**_____

How often are your complaints present?

☐ Constant 100% of the time	☐ Frequent 75%
☐ Intermittent 50%	☐ Occasional 25%

DESCRIBE YOUR PAIN

#2 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain **Unbearable**

Check all that apply to your #2 Complaint:

☐ Sharp	☐ Ache	☐ Tingling	☐ Sharp
☐ Stabbing	☐ Soreness	☐ Numbness	
☐ Burning	☐ Weakness	☐ Dull	
☐ Shooting	☐ Throbbing	☐ Constricting	

☐ **Other**_____

How often are your complaints present?

☐ Constant 100% of the time	☐ Frequent 75%
☐ Intermittent 50%	☐ Occasional 25%

DESCRIBE YOUR PAIN

#3 Complaint_____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No Pain **Unbearable**

Check all that apply to your #3 Complaint:

☐ Ache	☐ Tingling	
☐ Stabbing	☐ Soreness	☐ Numbness
☐ Burning	☐ Weakness	☐ Dull
☐ Shooting	☐ Throbbing	☐ Constricting

☐ **Other**_____

How often are your complaints present?

☐ Constant 100% of the time	☐ Frequent 75%
☐ Intermittent 50%	☐ Occasional 25%

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Is your Pain: ☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies
Was the onset: ☐ Gradual ☐ Sudden
Pain is aggravated by: ☐Walking ☐ Sitting ☐Lifting ☐ Standing ☐ Bending ☐ Stretching ☐ Twisting
☐ Riding in car ☐ Other _____

Pain improved by: ☐ Medication ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Therapy ☐ Chiropractic Adjustment
☐ Other _____

☐Yes ☐ No Is pain affecting your ability to work or be active? If yes, explain:_____
☐Yes ☐ No Any change in bowel/bladder infection, including stress incontinence? If yes, explain:_____
☐Yes ☐ No Any fever or chills? If yes, explain:_____
☐Yes ☐ No Any dizziness associated with symptoms? If yes, explain:_____
☐Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? If yes, explain:_____
☐Yes ☐ No Are your complaints affecting your sleep? If yes, explain:_____
☐Yes ☐ No Have you had any tests for this complaint? If yes, explain:_____
☐Yes ☐ No Any recent falls / accidents / surgeries / broken bones? If yes, explain:_____
☐Yes ☐ No Have you seen any other physicians in the past 6 months? If yes, explain:_____
☐Yes ☐ No Have you had any prior treatments, including physical therapy? If yes, explain:_____
☐Yes ☐ No Have you been in the hospital or had surgery for any reason? If yes, explain:_____
☐Yes ☐ No Have you ever been in an accident? If yes, explain:_____
☐Yes ☐ No Do you smoke? If yes, how much?_____
If you have quit smoking, when did you quit?_____

What **non-prescription** medication are you taking?
☐ Tylenol ☐ Aspirin ☐ Ibuprofen ☐ None ☐ Other _____
How often:☐ Daily ☐ Weekly ☐Other _____

What **prescription** medication are you taking?
☐Anti-inflammatory☐Birth Control Pill☐Pain Killers☐Muscle Relaxers☐Blood Pressure Meds☐Cholesterol Meds
☐Insulin☐Thyroid Meds☐Nerve Pills☐HRT☐Sleeping Aids☐Recent Antibiotics
☐Other _____ ☐None

Specify names if possible: _____

Are you taking any **supplements/vitamins**?
☐ Yes ☐ No
If yes, please list: _____

☐Yes ☐ No Do you consume alcohol more than socially?
☐Yes ☐ No Do you exercise? If yes, what is your routine?_____

Please circle regular dietary intake: fruits vegetables meats grains dairy products nuts/seeds/berries sugars Paleo/Primal gluten-free

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?
Mother: _____ Father: _____
Brother(s): _____ Sister(s): _____
Other: _____ Other: _____

Other health concerns? _____