



## Back to Wellness Chiropractic PATIENT INFORMATION SHEET

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential)

### PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What you prefer to be called: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Status: Married / Divorced / Single / Widowed

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Do you have children? Yes / No How many? \_\_\_\_\_

### EMERGENCY: Contact information for nearest relative or friend.

Who should we contact? \_\_\_\_\_ Relation: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

**PAYMENT METHOD:**  Cash  Check  Visa  Mastercard  Discover  American Express

### INSURANCE: If you have insurance please give your card to the office manager to be copied.

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Contract #: \_\_\_\_\_

### RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for payment.

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation? \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

**REASON for this visit:** \_\_\_\_\_ Date of injury \_\_\_\_\_

Work related accident?  Yes  No Auto Accident?  Yes  No Other Accident?  Yes  No



## Back to Wellness Chiropractic

### PATIENT CASE HISTORY

#### ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system and spine that can result in poor health. Following your exam, your chiropractor will outline a course care to begin to correct these layers of damage and to help you recover your inborn/innate health potential.

#### CURRENT PROBLEM

Chief complaint: \_\_\_\_\_

Describe the character of your pain:  Sharp/Stabbing  Dull/Ache  Throbbing  Burning  Tingling  Numb  Radiating to \_\_\_\_\_

How long have you been experiencing the problem? \_\_\_\_\_ Specific date if possible: \_\_\_\_\_

How often do you experience the symptom(s)?  Constant (76-100%)  Frequent (51-75%)  Intermittent (26-50%)  Occasional ( $\leq$  25%)

Is your pain:  Increasing  Decreasing  Not Changing

What makes the problem better? \_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

Are your complaints affecting your ability to work or activities of daily living?  No effect  Some physical restrictions  Need limited assistance with common everyday tasks  Have a significant inability to function without assistance  Are totally disabled/impaired

This is a *new* / *old* illness. It *was not* / *was* treated before. If treated before, what was done? \_\_\_\_\_

Name of Doctors: \_\_\_\_\_

Have you ever had chiropractic care before? *Yes* / *No* If yes, when? \_\_\_\_\_ Why? \_\_\_\_\_

#### CONFIDENTIAL HEALTH HISTORY

Weight: \_\_\_\_\_ lbs. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Have you ever had surgery or been hospitalized? *Yes* / *No* List Surgeries/Hospitalizations with dates: \_\_\_\_\_

List any medication(s) you are currently taking: (circle all that apply)

*Pain killers* / *Anti-inflammatories* / *Muscle Relaxers* / *Stimulants* / *Depressants* / *Other*: \_\_\_\_\_

Please list any past serious accidents with dates: \_\_\_\_\_

Do you have any family history of cardiovascular disease, cancer, or diabetes? (circle all that apply)

**For women only:** Are you pregnant? *Yes* / *No* \_\_\_\_\_ (Initial)

**WHAT IS YOUR HEALTH PHILOSOPHY?** (What are you currently doing to be healthy?) \_\_\_\_\_

#### HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?

\_\_\_\_\_ Temporary Relief (Help alleviate the symptom(s) but no permanent correction to the cause of the problem)

\_\_\_\_\_ Maximum Correction (Correct the cause of the problem for optimal health in the future)

**On a scale of 1 through 10** (10 being the most, 1 being the least), please rank your commitment to the following:

How committed are you at being at your maximum health potential?

1      2      3      4      5      6      7      8      9      10

How committed are you in wanting to get this problem handled once and for all?

1      2      3      4      5      6      7      8      9      10

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps         | <input type="checkbox"/> Influenza        | <b>INTAKE</b>                                  |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Smallpox      | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Coffee                |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Soda                  |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Alcohol               |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Cigarettes            |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago          | <input type="checkbox"/> White Sugar           |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Thyroid       | <input type="checkbox"/> Eczema           | <input type="checkbox"/> Artificial Sweeteners |

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:**

**MUSCULO-SKELETAL**

- Neck Pain
- Pain Between Shoulders
- Low Back Pain
- Arm/Leg Pain
- Joint Pain/Swelling/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

- Gas/Bloating
- Heartburn/Upset Stomach
- Black/Bloody Stool
- Colitis

**MALES ONLY**

- Prostate Sexual Dysfunction
- Impotence

**OTHER PROBLEMS**

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**Please outline on the diagram the area(s) of discomfort**

**NERVOUS SYSTEM**

- Nervousness
- Numbness/Tingling
- Paralysis
- Dizziness/Loss of Balance
- Forgetfulness/Memory Loss
- Depression
- Fainting
- Convulsions/Tremors
- Trouble Concentrating
- Stress

**C-V-R**

- Chest Pain
- High Blood Pressure
- Irregular Heartbeat
- Heart Attack
- Stroke
- Varicose Veins
- Ankle Swelling
- Shortness of Breath
- Asthma
- Wheezing

**GENERAL**

- Fatigue
- Allergies
- Loss of Sleep
- Frequent Colds/Flus
- Headaches/Migraines
- Tension/Irritable

**EENT**

- Blurred/Double Vision
- Loss of Smell or Taste
- Sore Throat
- Ear Aches/Infections
- Hearing Difficulty
- Ringing in Ears

**GASTROINTESTINAL**

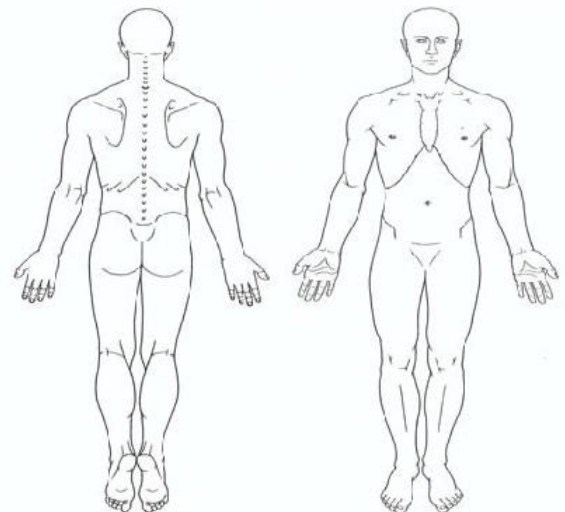
- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea/Constipation
- Hemorrhoids
- Kidney Problems
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

**FEMALES ONLY**

- When was your last Period?  
\_\_\_\_\_
- Are you trying to get pregnant?
- Yes
  - No
  - Menstrual Irregularity
  - Menstrual Cramps
  - Vaginal Pain/Infection
  - Breast Pain/Lumps

**FAMILY HISTORY**

- The following members have the same or similar problem(s) as I do:
- Mother
  - Father
  - Brother
  - Sister
  - Spouse
  - Child



**ABOUT YOUR CARE**

There are three phases of care that Chiropractic patients often go through. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (**VSC Vertebral Subluxation Complex**). This care often reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your goals.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statutes, to provide me with chiropractic care.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_