BACK 2 ACT

| CHIROPRACTIC & WELLNESS CENTER |

Confidential Patient Information:_____

1. ABOUT YOU
Today's Date:_____
Email Address:_____
Do you want to subscribe our E-Newsletter, promotion code via Email? ☐Yes ☐ No

Name:_____
Last First Mi Mr Mrs Ms Dr

I prefer to be called:_____ Male ☐ Female ☐

Birthday:_____/_____/_____ Age:_____ SS#_____

Home Address:_____
Apt/Condo#
_____
City State Zip

☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Windowed

Hm #: (_____)_____ Cell/Other #:_____

Wk #: (_____)_____ Ext:_____ DL #:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

How long there?_____ Occupation: _____

Where & when are best times to reach you?_____

Can we call you at work? Yes☐ No ☐

Other family members seen by us?_____

Whom may we Thank for referring you?_____

How did you hear about our clinic?

☐Family Members	☐Yellow Page	☐Internet website	☐Health class
☐Employer	☐Attorney	☐Billboard	☐Direct mail ad
☐Physician	☐Newspaper	☐Radio	☐Brochure
☐Friend	☐Sign on building	☐TV Commercial	☐Other

2. SPOUSE INFORMATION

His/Her Name:_____
Last First Mi

Employer:_____

Wk #: (_____)_____ Ext:_____ SS #:_____

Birthday: _____/_____/_____ DL #:_____

Emergency Contact:

His/ Her Name: _____ Relation:_____

Wk #: (_____)_____ Hm #: (_____)_____

3. MEDICAL HISTORY
Medical Condition:

☐Arthritis	☐Cancer	☐Diabetes
☐Hypertension	☐Psychiatric Illness	☐Skin Disorder

Surgeries:

☐ Appendectomy	☐Cardiovascular procedure	☐Cervical disc procedure
☐Joint replacement	☐Laminectomies	☐Radical prostatectomy

Allergies:

☐Eggs	☐Fish and Shellfish	☐Milk or Lactose	☐ Soy
☐Sulfites	☐Wheat/Gluten	☐Latex	☐Other:_____

Social History:

☐Caffeine used occasionally	☐Caffeine used often	☐Exercise not at all
☐Chew tobacco occasionally	☐Chew tobacco often	☐Exercise often
☐Drink alcohol occasionally	☐Drink alcohol often	☐feel stress often
☐Experience stress occasionally	☐Smoke more than 1 pack of day	

Family History:

☐Arthritis (parents) ☐Arthritis (sibling) ☐Cancer (parent)
☐Cholesterol (parents) ☐Cholesterol (sibling) ☐Diabetes (parent)
☐Heart problems (parent) ☐Heart problems (sibling) ☐High blood pressure
☐ Psychiatric (parent) ☐Psychiatric (sibling)

Substance Use:

☐Alcohol ☐ Amphetamines ☐Barbiturates ☐Barbiturates
☐Cocaine ☐ Crystal Meth ☐Heroine ☐Marijuana
☐ Other:_____ How long?_____

Children:

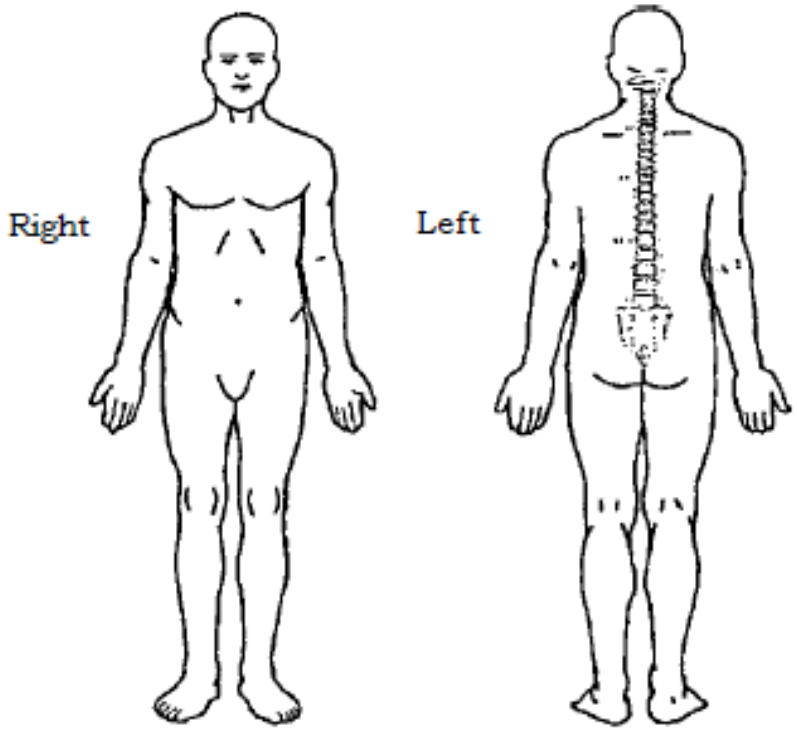
☐ Under 6 years ☐Under 10 years ☐Under 19 years

Occupational Activities:

☐Administration ☐Business owner ☐Clerical/secretarial ☐Computer user
☐Construction ☐Daycare/childcare ☐Executive/legal ☐ Food industry
☐ Health care ☐Heavy equipment operator ☐Household
☐Home service ☐Manufacturing
☐ Manual labor (OHeavy OMedium OLight) please check one.

Please indicate on the body diagram below, where are you experiencing the symptoms:

 # = Numbness X = Burning / = Stabbing 0 = Pins & Needles + = Dull Ache



Describe your symptoms:_____
_____
_____

When did your symptoms started?_____

How did your symptoms begin?_____

Is there anything that makes your symptoms worse?_____

Is there anything that makes your symptoms better?_____

Does the pain radiate or travel to any other part of your body? ☐Yes ☐No

If yes, where?_____

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐Occasionally (26-50% of the day) ☐Intermitting (0-25% of the day)

What describes the nature of your symptoms?
☐ Sharp ☐ Dull ache ☐Numb ☐ Shooting
☐ Burning ☐ Tingling ☐ Stabbing

How are your symptoms changing?
☐ Getting better ☐ Not changing ☐Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms:
(0=None to 10 = Unbearable)
☐ 0 = none ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 (unbearable)

During the past 4 weeks, how much has pain interfered with your daily activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐Quite a bit ☐Extremely

In general, would you say your overall health right now is.....
☐ Excellent ☐Very good ☐ Good ☐ Fair ☐Poor

Who have you seen for your symptoms:
☐No one ☐Other Chiropractor ☐ Medical Doctor ☐Physical Therapist
☐ Other

What treatment did you receive for your symptoms?
☐Adjustments ☐ Physical Therapy ☐ Medication ☐Surgery
☐Other

When did you receive this treatment?
☐ In the last month ☐ 2-3 month ago ☐3-6 months ago
☐ 6 months to 1 year ago ☐ 2-5 years ago ☐ 5-10 years ago

What tests have you had for your symptoms?
☐ X-rays ☐ MRI ☐ CT Scan ☐Other

When were these tests done?
☐ In the last month ☐ 2-3 months ago ☐ 3- 6 months ago
☐ 6 months to 1 year ago ☐ 1-2 years ago ☐ 2-5 years ago ☐ 5 years +

Have you had similar symptoms in the past?
☐Yes ☐ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?
☐This office ☐ Other Chiropractor ☐Medical Doctor ☐ Physical Therapist
☐Other

What is your occupation?
☐Professional/Executive ☐White Collar/Secretarial ☐ Tradesperson
☐ Laborer ☐ Homemaker ☐ Full-time student
☐ Retired ☐Other

If you are not retired, a homemaker or a student, what is your work status?
☐Full-time ☐Part-time ☐ Self-employed ☐Unemployed
☐ Off work ☐Other

Is there anything else you want to tell me about your current chief compliant?
_____
_____
_____

_____ _____ _____
Signature of Patient or Guardian | Printed Name of Patient or Guardian | Date