Back In Action Chiropractic

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Confidential Health Information

Please allow the staff to copy your driver's license and insurance card. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly. When appropriate, please circle the word or check the box that applies to you.

Today's Date _____

Have you consulted a chiropractor before? Yes No When was your last visit_____

Whom may we thank for referring you?_____

Last Name _____ Male Female Marital Status_____

First Name _____ Middle Initial _____ Birthday _____

Address _____ Race_____

City _____ State _____ Zip code _____

Social Security Number _____

Best Contact Phone Number: Home Cell Work _____ 2nd number_____

Email address _____ Occupation _____

Employer Name and Address _____

May we contact you at work? Yes No Preferred method of contact Home Phone Cell Phone Office Phone Email

Do you have health insurance that covers chiropractic? Yes No Does your insurance require a referral? Yes No

Policyholder Name _____ Policyholder Birthday_____

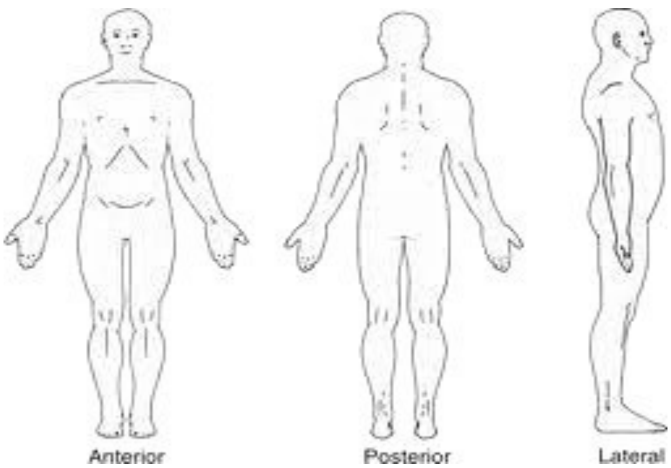
Insurance Company Name _____ Primary Care Provider Name_____

Insurance ID# _____ Relationship to Policyholder_____

Insured's Employer and address_____

Where does it hurt? Mark a "0" for current conditions

"X" for past conditions



__ Numbness/ Tingling
__ Stiffness
__ Dull Pain
__ Aching
__ Cramps
__ Nagging
__ Sharp
__ Burning

__ Shooting
__ Throbbing
__ Stabbing
__ Other ____________________
__ Other ____________________

Are your present problems due to an injury? ❑ Yes ❑ No Enter the date of the injury: ________________________

Was the injury? ❑ Job Related ❑ Auto Accident ❑ Personal Injury ❑ Other: ______

Has the accident been reported? ❑ Yes ❑ No If so, to whom? ❑ To Employer ❑ Auto Carrier ❑ Other:

Briefly describe the accident, injury or illness:____

____

____

____

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

___________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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List any tests, studies or medications received for this condition:

❑ Tests/Studies: ____

❑ Medications: ____

Where you admitted to the hospital due to this condition: ❑ Yes ❑ No

If yes, what hospital? _____________________Transported by? ❑ Ambulance ❑ Police ❑ Other: ____________

Date Admitted: ________________ Date Released: _____________ Length of Stay: _______________

List the hospital procedures received: ____

List symptoms you are experiencing today: Choose the severity level associated with each symptom

__________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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Some health issues are hereditary. Please let us know about the health of your immediate family.

Relative	Age (if living)	State of Health	Illnesses	Age of Death	Cause of Death
Mother	_____	Good Poor	____________________________	_______	Natural Ill-ness
Father	_____	Good Poor	____________________________	_______	Natural Ill-ness
Sister	_____	Good Poor	____________________________	_______	Natural Ill-ness
Sister	_____	Good Poor	____________________________	_______	Natural Ill-ness
Brother	_____	Good Poor	____________________________	_______	Natural Ill-ness
Brother	_____	Good Poor	____________________________	_______	Natural Ill-ness

Are there any other hereditary issues that you know about?

____

Social History

Alcohol Use __ Daily __ Weekly How much? ______________________________ Prayer/Meditation? Yes No

Coffee Use __ Daily __ Weekly How much? _______________________________ Job Pressure/Stress? Yes No

Tobacco Use How much? (Quit Date if former smoker) _____________________ Financial Peace? Yes No

Exercising __ Daily __ Weekly How much? _________________________________ Vaccinated? Yes No

Pain Relievers __ Daily __ Weekly How much? ____________________________ Mercury Fillings? Yes No

Soft Drinks __ Daily __ Weekly How much? _______________________________ Recreational Drugs Yes No

Water Intake per day ____

Hobbies

____

What is the major stressor in your life? _____ Average number of hours of sleep_____

What is the type and approximate age of your mattress? _____ Pillow? _____

What is your preferred sleeping position? _____

Describe your typical eating habits __ Skip Breakfast __ Two Meals/Day __ Three Meals/Day __ Snacks

What would be the most significant thing you could do to improve your health?

_____

How does this condition currently interfere with your life and ability to function?

No Effect Mild Moderate SevereNo Effect Mild Moderate Severe

Do you have any current work restrictions due to this condition?

Off work: Yes No Previously From: _____ To: _____

Light duty: Yes No Previously (If yes, what are/were your restrictions?) _____

What type of work do you do?_____

_____

Do you suffer from any condition other than that for which you are now consulting us? Yes No

_____

List any past conditions you may have had: _____

Are you taking any medication (prescription or over-the-counter)? ❑Yes ❑No

If Yes, please indicate the following:

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Medication: _____ Medication: _____

Route: Oral Route: Oral

Intravenous Intravenous

Other: _____ Other: _____

Frequency: _____ Frequency: _____

Began Use: _____ Began Use: _____

Discontinued Use: _____ Discontinued Use: _____

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: _____

Do you have allergies to medication? ❑Yes ❑No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
_____	Back Operation	_____	Hernia	_____	Gall Bladder
_____	Female Organs	_____	Thyroid	_____	Stomach

Other _____

Have you ever had X-rays taken? ❑Yes ❑No When? _____ By Whom? _____

For what ailments were these X-rays taken? __

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS
- ❑ Allergy(What) ____ _____
- ❑ Bronchitis
- ❑ Chills (Constant)
- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Night Sweats
- ❑ Numbness or Pain in arms/legs/hands
- ❑ Wheezing

GASTRO-INTESTINAL
- ❑ Belching or Gas
- ❑ Colon Trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids (piles)
- ❑ Jaundice
- ❑ Liver Trouble
- ❑ Nausea
- ❑ Stomach Pain
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Heart Burn
- ❑ Bloody Stools
- ❑ Acid Reflux
- ❑ Irritable Bowel

EYE/EAR NOSE/THROAT
- ❑ Asthma
- ❑ Deafness
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ear Noises
- ❑ Thyroid Problems
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Pain in Eyes
- ❑ Poor Vision
- ❑ Blurred Vision
- ❑ Sinusitis
- ❑ Sore Throats
- ❑ Tonsillitis

RESPIRATORY
- ❑ Chest Pain
- ❑ Chronic Cough
- ❑ Difficulty Breathing
- ❑ Spitting Blood
- ❑ Spitting Phlegm

GENITO-URINARY
- ❑ Bed Wetting
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Inability to Control Urine
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Painful Urination
- ❑ Prostate Trouble

MUSCLES & JOINTS
- ❑ Backache
- ❑ Foot Trouble
- ❑ Hernia
- ❑ Pain Between Shoulders

CARDIO-VASCULAR
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chest Pain
- ❑ Heart Trouble
- ❑ Poor Circulation

SKIN OR ALLERGIES
- ❑ Bruising Easily
- ❑ Dryness
- ❑ Eczema
- ❑ Hives or Allergy
- ❑ Itching

FOR FEMALES ONLY
- ❑ Cramps
- ❑ Hot Flashes
- ❑ Irregular Cycle
- ❑ Painful Periods
- ❑ Vaginal Discharge

❑ Painful Tail Bone	❑ Rapid Heart	❑ Sensitive Skin	❑ Pregnant Now?
❑ Stiff Neck	❑ Slow Heart	❑ Skin Eruptions	_____ Last Pap Date
❑ Spinal Curvature	❑ Strokes		_____ Last Menstrual
❑ Swollen Joints	❑ Swelling Ankles		Cycle
❑ Tremors	❑ Varicose Veins		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

To set clear expectations, improve communications and help you get the best results in the sortest amountof time, please read each statement and initial your agreement.

_____ I instruct the chiropractor to deliver the care that her professional judgement can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxsation. Chiropractic is a seprate and distince healing art from medicine and does not proclaim to cure any named disease or entitiy.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ You will have the opportunity to talk to your doctor and staff members in private. However, this practice may provide treatment in in an open area. This means staements made by you, or practice empoyess, during treatment may be overheard by others. If you have comments you wish to make privately when you are brought to the treatment area or during treatment, please inform the doctor or staff so that we may honor your reqauest.

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of care from this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any uncovered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

If the patient is a minor child, please print the child's full name : _____

_____ _____

Patient/Guardian Signature Date

Receipt of Notice of Privacy Practices Acknowledgment Form

I hereby acknowledge that on _____ I received the Notices of Privacy Practices from Back In Action Chiropractic, which sets forth the ways in which my personal health information may be used or disclosed by Back In Action Chiropractic, and outlines my rights with respect to such information.

_____

Print Name

_____ _____

Signature Date