Back to Basics Chiropractic
1420 Hustonville Road Danville, KY 40422-2424
Phone: (859) 236-5562 Fax: (859) 236-5564

Patient Information

Name: (First, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: M F Marital Status: Single Married Widowed Divorced

Home Phone:_____ Cell Phone: _____Work Phone:_____ Preferred Name: _____

For text message appointment reminders please provide your cell phone carrier:_____

Employment Information

Maiden Name:_____ Employment Status: Employed Part-time Student Full-time Student Other

Employer:_____ Occupation: _____

Insurance Policy Holder Information/Responsible for Bills (If different from patient)

Address: _____ (City, State, Zip): _____

Name : _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Policy #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

SSN #: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____
Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

Employment Emergency Accident Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? Yes No

Employer Contact Name: _____ Employer Contact Phone and Extension: _____

Consent to Treatment/Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.
I hereby assign, transfer, and set over to Back to Basics Chiropractic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance

I certify that I have read this form and understand its contents.
Patient or Other Legally Authorized Person: _____ Date: _____

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Medical History

Conditions:

- Arthritis
- Hypertension
- Cancer

Allergies:

- Eggs
- Soy
- Shellfish
- Sulfites
- Milk
- Wheat/Gluten
- Peanut

Surgeries:_____

Family History:

- Arthritis
- Cholesterol
- Heart Problems
- Psychiatric
- Thyroid
- Diabetes
- Skin Disorder
- Heart Disease
- Stroke
- Cancer
- High Blood pressure
- Stroke
- Psychiatric Illness

Occupation Activities:

- Administration
- Construction
- Health care
- Homemaker
- Daycare/childcare
- Construction/Manual labor

Substance Abuse (circle one if checked):

- Alcohol (present/past)
- Barbiturates (present/past)
- Crystal Meth (present/past)
- Marijuana (present/past)
- Amphetamines (present/past)
- Cocaine (present/past)
- Heroine (present/)

Tobacco Use:

- Often
- Sometimes
- Occasional

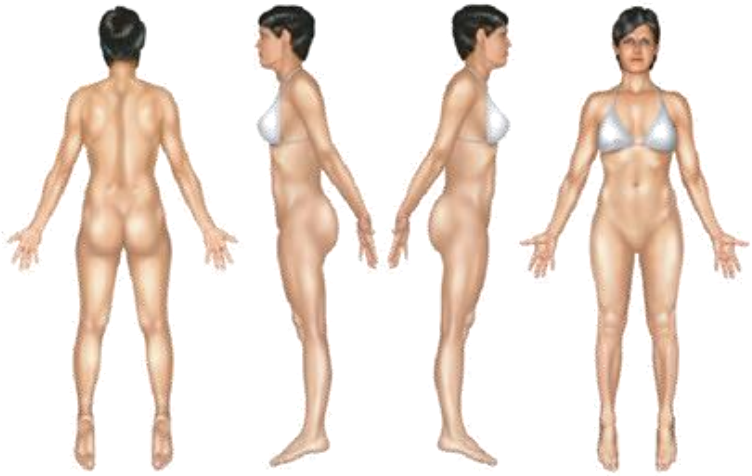
Exercise:

- Often
- Sometimes
- Occasional

Symptoms

Using the follow key, indicate on the body diagram where you are experiencing the following symptoms:

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



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Describe your symptoms:
_____
_____

How did symptoms
begin?_____

Date Symptoms Began (if caused by accident):_____

Frequency of Symptoms:

- o Constantly (76-100% of the day)
- o Frequently (51-75% of the day)
- o Occasionally (26-50% of the day)
- o Intermittently (0-25% of the day)

Nature of Symptoms:

- o Sharp
- o Burning
- o Dull ache
- o Tingling
- o Numb
- o Stabbing
- o Shooting

Average intensity of symptoms (0 none to 10 unbearable): _____
How much has your pain interfered with your normal day (work and home):

- o All the time
- o Most of the time
- o Some of the time
- o A little of the time

Prior Treatment

Have your seen someone else for treatment:

- o No
- o Chiropractor
- o Medical Doctor
- o Physical Therapist

Last treatment received:

- o Last month
- o 1-2 Years
- o 3-6 months
- o 6-9 months

Have you had any testing done and when:

- o X-Ray _____ MRI_____ CT _____ Other _____

Similar symptoms in the past: _____

Past treatment for similar symptoms:

- o This office
- o Other chiropractor
- o Doctor
- o Physical therapist
- o Other

How Were You Referred to Our Office?

Doctor Friend/Patient Other

Referral Name_____

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