



**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)**

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: \_\_\_\_\_

Please print the name of your source: \_\_\_\_\_

**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: \_\_\_\_\_

**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)
- Heroin (present/)

**Tobacco Use:**

- Often
- Sometimes
- Occasional

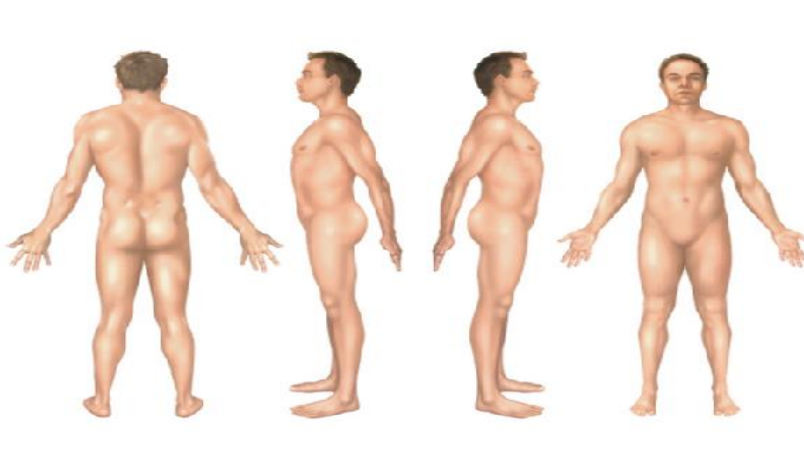
**Exercise:**

- 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:**

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

**Nature of Symptoms:**

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

**Average intensity of symptoms (0 none to 10 unbearable):** \_\_\_\_\_

**How much has your pain interfered with your normal day (work and home):**

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

**Prior Treatment**

**Have you seen someone else for treatment:**

- No
- Chiropractor
- Medical Doctor
- Physical Therapist

**Last treatment received:**

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

**Have you had any testing done and when:**

- X-Ray \_\_\_\_\_ MRI \_\_\_\_\_ CT \_\_\_\_\_ Other \_\_\_\_\_

**Similar symptoms in the past:** \_\_\_\_\_

**Past treatment for similar symptoms:**

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

**How Were You Referred to Our Office?**

Doctor    Friend/Patient    Other

Referral Name \_\_\_\_\_