BACK TO BASICS CHIROPRACTIC

Patient Information Date______________

Name____________________________________ **Nickname**__________________________ **Sex** M/F
Maiden Name______________________________ **Marital status** Single/Married/Widowed/Divorced
Date of Birth______________________________ **Age**__________ **Social Security**____________________
Occupation______________________________ **Employer**______________________________________
Address____
City_______________________________________ **State**________ **Zip code**_________________________
Cell Phone_________________________________ **Work Phone**_____________________________________

Insurance Policy Information

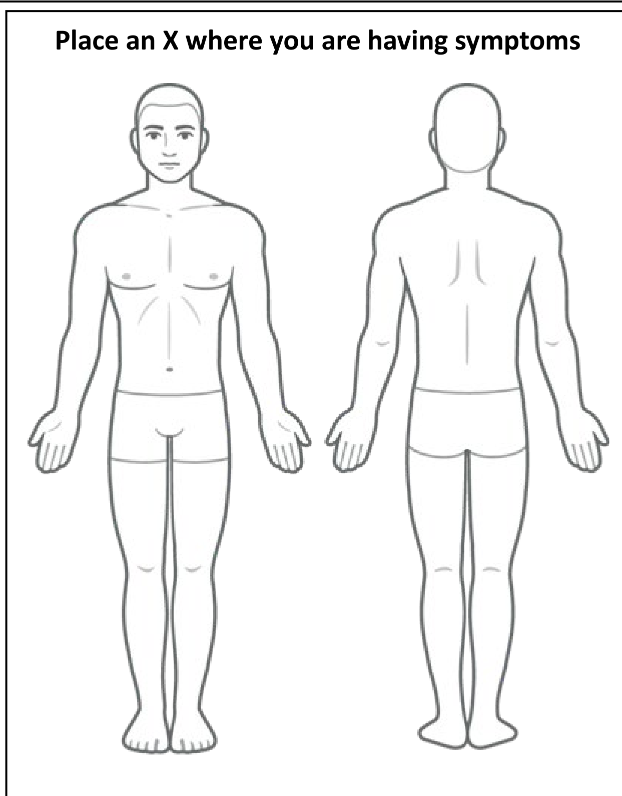
Name____________________________________ **Date of Birth**____________________________________
Policy Number_____________________________ **Responsible Party's Phone Number**________________
Relationship to Patient_______________________ **Social Security**_________________________________

Emergency Contact Information

Name______________________ **Relationship**_________________ **Contact Information**_______________

Symptoms___________________________________
Date Symptoms Began________________________
Type of Accident
Auto/ Work/Home
What is Your Average Level of Pain:
(No Pain)0 1 2 3 4 5 6 7 8 9 10(unbearable)
Frequency
Constant or Intermittent
Quality of Symptoms
Ache Sharp Dull Stinging Stiffness Burning
Numbness Tingling Dizziness Other____________
Activities That Increase Pain
Movement Twisting Bending Lifting Sitting
Standing Walking Driving Lying Down
Other___________
Activities That Decrease Pain
Rest Movement Medication Sitting Standing
Lying Down Heat Ice Topical Cream
Other___________
Fractures
____
Surgeries
____

Place an X where you are having symptoms



Prior Treatment

Have you received prior treatment for this condition?
Chiropractor____ Medical Doctor_____ Physical Therapist____ Other___________________________________
Have you received and testing for this condition?
X-ray____ MRI____ CT____ Blood test____ Other____
Have you had similar Symptoms in the Past?
Yes____ No____ (If yes, explain)____
Are you pregnant?
Yes____ No____ Due Date____

How Did You Hear About Us?

Referral Name______________________

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Family Medical History

Arthritis	Y__N__	Thyroid	Y__N__	High Blood Pressure	Y__N__
Cholesterol	Y__N__	Diabetes	Y__N__	Cancer	Y__N__
Heart Problems	Y__N__	Skin Disorder	Y__N__	Stroke	Y__N__
Psychiatric	Y__N__	Heart Disease	Y__N__	Other________________________	

Patient Medical History

Exercise	**Tobacco use**	**Substance Abuse**
None	Packs per day_____	Alcohol (past/Present)
Moderate	**Alcohol use**	Barbiturates (past/Present)
Daily	Drinks per day____	Amphetamines (past/Present)
Heavy	**Caffeine use**	Cocaine (past/Present)
	Cups per day_____	Heroine (past/Present)

Medications

____

____

Allergies

____

____

Are you experiencing any of the symptoms		**Have you been diagnosed with any of the following**	
Fever	Y__N__	Stroke	Y__N__
Fatigue	Y__N__	Cancer	Y__N__
Weight Loss/gain	Y__N__	Migraines	Y__N__
Nausea	Y__N__	Diabetes	Y__N__
Vomiting	Y__N__	thyroid issues	Y__N__
Heartburn	Y__N__	Parkinson's	Y__N__
Painful Swallowing	Y__N__	Kidney Disease	Y__N__
Change in Stool	Y__N__	Heart Disease	Y__N__
Change of Bowel control	Y__N__	Blood Disease	Y__N__
Change of Bladder Control	Y__N__	Fractures	Y__N__
Sore Throat	Y__N__	Disc Herniations	Y__N__
Hoarseness	Y__N__	Miscarriage	Y__N__
Chest Pain	Y__N__	Tumors/Growths	Y__N__
Palpitations	Y__N__	High Cholesterol	Y__N__
Cough	Y__N__	High blood Pressure	Y__N__
Shortness of Breath	Y__N__	Gout	Y__N__
Wheezing	Y__N__	Rheumatoid Arthritis	Y__N__
Blurred Vision	Y__N__	Ulcers	Y__N__

I voluntarily consent to receive medical and health 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. The 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:_____________