BACK IN ACTION
CHIROPRACTIC

TODAY'S DATE: ______________________

PATIENT ID:______________________________

PATIENT INFORMATION

Name: (Last)_____________________________________ (First)____________________________ (Middle Initial)______

Address:____

City:______________________________________ State:_____________________________ Zip:____________________

Home Number:____________________ Work Number:_______________________ Cell number:_____________________

E-mail Address: ______________________________________ May we leave messages at the above numbers ☐ Yes ☐ No

Birth Date:_______________________ Sex: ☐ Male ☐ Female Preferred Greeting Name:_______________________

Relationship to Policyholder: ☐ Same ☐ Spouse ☐ Child ☐ Other ____

Patient Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ______________________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed ☐ Student

Occupation:___________________________ Employer's Name:_____________________ Phone Number:______________

Referred to Office by: ☐ Doctor ☐ Friend ☐ Facebook ☐ Instagram ☐ Family ☐ Insurance List ☐ Internet Search
☐ Other ____

INSURANCE INFORMATION

Primary Insurance:____ Phone:______________________________

Address:____

Policy Claim Number:____ Group #:___________________________________

Check box if the following information has been completed above: ☐ Information Completed

Policyholder's Name (if different than above): (Last)_____________________________ (First)______________________

Address:____

City:________________________ State:________________ Zip:______________ Home Phone:______________________

Birth Date:________________________ Sex: ☐ Male ☐ Female

Secondary Insurance:____ Phone:_________________________________

Address:____

Policy Claim Number:____ Group #:___________________________________

Check box if the following information has been completed above: ☐ Information Completed

Policyholder's Name: (Last)_____________________________ (First)_________________ (Initial)__________________

Address:____

City:________________________ State:________________ Zip:______________ Home Phone:______________________

Birth Date:________________________ Sex: ☐ Male ☐ Female

BACK IN ACTION
CHIROPRACTIC

Name:______________________________

Date:______________________________

CURRENT SYMPTOMS/COMPLAINTS

Have you ever seen a chiropractor before? ☐ yes ☐ no If yes, when and why? ______________________

____

Reason for today's visit? ____

Have you had a similar condition in the past? ☐ yes ☐ no

If you have been injured, are your complaints related to a(n):

☐ Auto Accident
☐ Work Injury
☐ Sports Injury
} Please provide date of injury:____

☐ Other (please describe): ____

____

When did the current symptom(s)/pain begin? ______________________________________

If you are in pain, is it: ☐ improving ☐ remaining the same ☐ worsening

How often is there pain: ☐ constant (76-100%) ☐ frequent (51-75%) ☐ occasional (26-50%) ☐ intermittent (0-25%)

Does the pain interfere with: ☐ work ☐ sleep ☐ recreation ☐ daily routine ☐ mood and irritability

Have you been treated by anyone else for this condition? ☐ yes ☐ no If yes, what treatment have you received and who administered this treatment? Type of care received_____________________________

Name of facility/doctor:____

Results of care: ☐ positive ☐ no change ☐ other If other, please explain: __________________

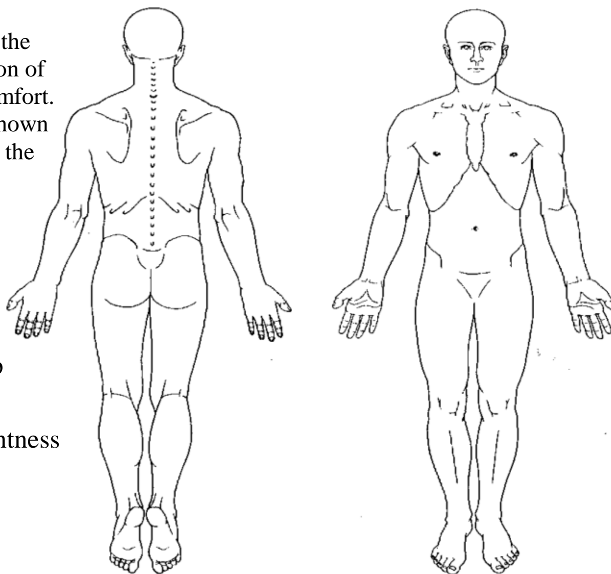
Which of the following activities are difficult to perform due to the pain? (mark all that apply)

☐ Laying on back
☐ Laying on stomach
☐ Laying on side
☐ Turning over in bed
☐ Getting Dressed
☐ Bending forward
☐ Bending backward
☐ Standing for long periods of time
☐ Getting in/out of seated position
☐ Working at a computer/desk
☐ Pushing/pulling
☐ Twisting
☐ Reaching
☐ Kneeling
☐ Gripping
☐ Walking
☐ Sitting
☐ Getting in/out of car
☐ Sneezing/Coughing
☐ Other:___________

PAIN RATING

Please indicate on the drawing the location of your pain or discomfort. Use the symbols shown below to represent the type(s) of pain:

D=Dull Ache
B=Burning
N=Numbness
S=Stabbing/Sharp
T=Tingling
X=Stiffness/Tightness
O=Spasm



Area	Rating
Headache	**0 1 2 3 4 5 6 7 8 9 10**
Neck	**0 1 2 3 4 5 6 7 8 9 10**
Shoulder	**0 1 2 3 4 5 6 7 8 9 10**
Arms	**0 1 2 3 4 5 6 7 8 9 10**
Wrist/hand/fingers	**0 1 2 3 4 5 6 7 8 9 10**
Upper Back	**0 1 2 3 4 5 6 7 8 9 10**
Mid Back	**0 1 2 3 4 5 6 7 8 9 10**
Low Back (beltline)	**0 1 2 3 4 5 6 7 8 9 10**
Legs/Knees/Feet	**0 1 2 3 4 5 6 7 8 9 10**
Hips	**0 1 2 3 4 5 6 7 8 9 10**

BACK IN ACTION
CHIROPRACTIC

Name:______________________________

Date:______________________________

PAST HEALTH HISTORY

Please check the box located next to the condition or symptom listed below in which you now have or have had previously. It is important to know your health history so that we can provide the highest quality of care for you. This report is confidential.

GENERAL HEALTH
- ☐ Allergies
- ☐ Seizure
- ☐ Dizziness or fainting
- ☐ Headache
- ☐ Numbness

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Bursitis
- ☐ Sciatica
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Middle back pain
- ☐ Swollen joints
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Leg pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot pain

GASTRO-INTESTINAL
- ☐ Acid-reflux
- ☐ Colon trouble
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Difficult digestion
- ☐ Gall bladder trouble
- ☐ Liver trouble
- ☐ Stomach pain

EYES, EARS, NOSE, & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noise
- ☐ Ear pain
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Sinus infection or trouble

CARDIO-VASCULAR
- ☐ Heart attacks
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of Ankles

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting up blood
- ☐ Spitting up mucous
- ☐ Wheezing

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Blood urine
- ☐ Frequent urination
- ☐ Bladder control
- ☐ Bladder infections
- ☐ Prostate trouble
- ☐ Painful urination

SKIN
- ☐ Bruise easily
- ☐ Dryness
- ☐ Rashes
- ☐ Varicose veins

If you feel an explanation is needed, you may use this space. ______________________________
____
____

FAMILY HEALTH HISTORY

CHECK THE BOXES OF THE FOLLOWING CONDITIONS YOU HAVE OR HAD AND **CIRCLE** THE CONDITIONS THAT MAY RUN IN YOUR FAMILY.

☐ AIDS	☐ ALCOHOLISM	☐ ANEMIA	☐ APPENDICITIS	☐ ARTERIOSCLEROSIS
☐ CANCER	☐ DIABETES	☐ ECZEMA	☐ EMPHYSEMA	☐ EPILEPSY
☐ GOITER	☐ GOUT	☐ HEART DISEASE	☐ MALARIA	☐ MEASLES
☐ MULTIPLE SCLEROSIS		☐ MUMPS	☐ PACEMAKER	☐ PNEUMONIA
☐ POLIO	☐ STROKE	☐ TUBERCULOSIS	☐ ULCERS	☐ VENEREAL DISEASE

MEDICATIONS / SUPPLEMENTS

Please list any current dietary supplements, prescription and/or over-the-counter medications and reason for use:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

BACK IN ACTION
CHIROPRACTIC

Name:________________________________

Date:________________________________

PERSONAL HEALTH

Have you in the past had any surgeries of any kind? ☐ yes ☐ no If yes, please explain ____________________

____

Is there any chance that you may be pregnant? ☐ yes ☐ no If yes, when are you due?______________

How often do you exercise? ☐ daily ☐ 3-5 days per week ☐ 1-2 days per week ☐ 0 days per week

Type of exercise: ☐ cardio-vascular ☐ weight or resistance training ☐ Core stabilization ☐ other

If other, please explain ____

	None	Light	Moderate	Heavy
ALCOHOL USE				
COFFEE USE				
TOBACCO USE				
DRUG USE (non Rx)				
SOFT DRINK USE				

	Date of most recent:
Physical Exam	
Blood Test	
Urinalysis	
Chest X-ray	
Spinal X-ray	

Name and location of Primary Care Physician: ____

Do you authorize Back In Action Chiropractic to correspond with your Primary Care Physician or other involved health care providers about your care? ☐ yes ☐ no

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions and filled out this form completely.

Sign your name ____ Date ______________________

DOCTOR'S NOTES

L O

O P

C P

Q Q

S R

M S

A T

T

ROS

Personal Hx

Fam Hx

Soc Hx

BACK IN ACTION
CHIROPRACTIC

PATIENT NAME: ____

Welcome to Back in Action Chiropractic and for choosing us to help you with all of your health care needs. Our mission is to provide the highest quality of chiropractic care to the members of our community and to help educate you about your health and the steps that you can take to ensure good health for a lifetime. Before receiving care in our office it is important to be familiar with our policies:

CONSENT TO TREAT: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic those working at the clinic or office who or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below. I have the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives. I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to exam and treatment however I do not expect the Doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. By signing below, I consent to the treatment plan, I intend this consent to form to cover the entire course of treatment for my condition and for any past or future condition(s) for which I have been under care or will seek. . **_____Initial**

INSURANCE ASSIGNMENT: Back in Action Chiropractic is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim or reimbursement of charges incurred by me as a result of professional services rendered by Back in Action Chiropractic. I do hereby assign irrevocable direct payment to the health care professionals, and any contractees, the health care benefits due for the total charges or payments equal to the reimbursement rate as may be appropriate, for any services not covered by this assignment. I hereby instruct and direct any obligated company or individual to pay check made out and mailed to Back in Action Chiropractor. **_____Initial**

FINANCIAL AGREEMENT: Payment of co-pays and non-insurance covered services is expected at the time of service. I agree, whether I am signing as agent or as a patient, that in consideration of the services to be rendered to the patient, I individually obligate myself to pay the account of the health care professional in accordance with the regular rates and terms of the health care professionals. I understand that the health care profession shall have the right at any time to refuse to admit me or provide health care treatment for me. The health care professionals, as a courtesy to the patient, agree to extend credit by awaiting payment from the insurance company, provided any deductible and co-payment are paid on a per-visit-basis for no longer than 60 days from the date of service at which time the account is due and payable. If the patient should discontinue treatment against the recommendations of the health care professional, then the entire balance is due and payable immediately. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney fees and collection expenses. There will be a $15.00 charge for returned checks. I further agree that the above mentioned health care provider be given power of attorney to endorse/sign my name on any checks for the payment of my health care professional's bill. Should an over-payment be made, a refund check will be sent to the authorized party that is due the over-payment. The health care professional reserves the right to have billing services performed by a contracted billing service and the health care professional reserves the right to charge the patient an amount equal to the billing services rate for any over-payment**.** **_____Initial**

APPOINTMENTS: A missed appointment is a loss to everyone. Please give 24 hours notice if you are unable to keep your appointment; **otherwise we reserve the right to charge $30 for the time reserved.** This charge is **your responsibility**, as insurance companies do not pay for missed appointments**.** **_____Initial**

The undersigned certifies that he/she has read and understood the foregoing is entitled to a copy of the same upon request, and is the patient, or is duly authorized as the patient's general agent to execute the above and accept its terms.

______________________________	______________	______________________________
Patient's or Responsible Party's signature	**Date of Signing**	**Relationship to Patient**