

Welcome to Back 2 Health Chiropractic

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age _____ Today's date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home # () _____ Work # () _____ Ext. _____ Soc. Sec. # _____ - _____ - _____
 Fax # () _____ Beeper/Cellular # () _____ **E-mail Address** _____
 ___ Male ___ Female # of Children _____ Single Married Significant Other Widowed Separated Divorced
 Your occupation _____ Work duties _____ **WOMEN ONLY: Are you pregnant? No ___ Yes ___**
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
Who may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

Your Health Profile

***CHECK ONLY THOSE CONDITIONS THAT APPLY.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Numbness/Tingling/Pain in (Arms / hands/ fingers)
R / L Both | <input type="checkbox"/> Hip Pain R / L | <input type="checkbox"/> Neck Stiffness/ Pain
R / L Both | <input type="checkbox"/> Back Stiffness/Pain |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Colds / Flu | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Swollen Painful Joints | <input type="checkbox"/> Tremors | <input type="checkbox"/> Blurred Vision R / L | <input type="checkbox"/> Double Vision R / L |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Pain w/ Cough / Sneeze | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Buzzing/Ringing in ears | <input type="checkbox"/> Sinus Problems/Allergies | <input type="checkbox"/> Nervousness/Anxiety |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability/Mood Swings | <input type="checkbox"/> Tension/Stress |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Recurring Infection | <input type="checkbox"/> Diarrhea/Constip./Gas |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Jaw/TMJ Problems |
| <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Heartburn/Reflux |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> PMS | <input type="checkbox"/> Menopause | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High Blood pressure | | <input type="checkbox"/> Cancer (Type) _____ | |
| <input type="checkbox"/> Other _____ | | | |

Additional Explanation: _____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No

Was this due to an accident/Trauma? Yes No

If Yes, explain.(ex. fall, auto, sports,) _____

Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels? _____

Severity of pain: Mild Moderate Severe

Does this pain travel or radiate? If so, where? _____

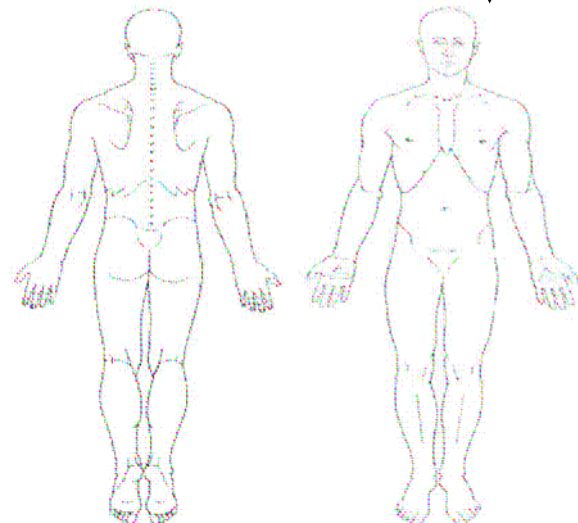
Quality: (mark all that apply) Radiating Dull/Aching

Localized Diffuse Stabbing Tingling

Burning Localized Shooting Sharp

Patient Name: _____

Please mark on the diagram below the area of discomfort. ↓



Date: _____

Timing:

- Worse AM Worse PM Worse W/ Activity Worse Sleeping
- Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

How often do you find yourself suffering from this problem? _____

How long does the problem last? (all the details of timing) _____

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Changing Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions?

How do you want us to handle your problem?

- ____ Temporary **Relief** (I just want to get out of pain and nothing else)
- ____ Maximum **Correction** (Correct the cause of the problem for maximum stability in the future)
- ____ I want to get set up on a Spinal Maintenance/**Wellness** program

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Signature

____/____/____
Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

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