Back & Body Chiropractic Center
Health Information and Health History

Patient Name:_____ Gender: Male Female

Marital Status: (Circle one) M S D W Other: _____ Date of Birth ____/____/____

Spouse Name: _____ How many children: _____

Patient Social Security Number: _____-_____-_____

Spouse Social Security Number: _____-_____-_____

Patient Address: _____ City _____Zip Code:_____

Patient Phone Number: _____-_____-_____ Cellular Number: _____-_____-____

Email:_____ ___ Employer:_____

Occupation: _____ Referred By:_____

Is this condition due to: Auto Accident Personal Injury Work Related Accident

Do you have health insurance? Yes No

Do you have more than one insurance? Yes No

Name of Insurance Company: _____ID #_____

Is your spouse employed? Yes No Is your spouse the primary insured? Yes No

Are you covered by Medicare? Yes No

I authorize Back & Body Chiropractic Center to release medical information to my insurance company:

Signature: _____Date_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment of services is due at the time of service unless other financial arrangements have been made.

Signature: _____Date_____

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COMPLAINTS

Primary Complaint? _____

Secondary Complaint? _____

When did your problem begin? _____

How did your problem begin? _____

Is this problem interfering with your: (circle one)

Activities of daily living Work Social Activities Hobbies Sleep

Rate your pain: (Circle one) 0 being no pain or 10 being the worst pain
0 1 2 3 4 5 6 7 8 9 10

Is your health problem worse: (Circle one) Morning Day Evening Night

Does your health problem occur: (Circle one)

Occasionally Intermittently Constantly Frequently

Is your problem getting: (Circle one) Better Worse Staying the Same

Have you had this problem before? _____ When? _____

What aggravates your health problem: circle all that apply and others _____

Coughing	Sneezing	Walking
Reaching	Lifting	Bending
Sitting	Lying down	Standing
Neck movement		Straining at stool

What relieves your health problem: circle all that apply and others _____

Nothing	Resting	Heat
Sitting	Standing	Ice

Have you had recent treatment for this condition? Yes No
Who did you see? _____Treatment _____

Have you had any changes in bowel or bladder habits since your problem began? Yes No

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List your hobbies: 1) _____
2) _____
3) _____

What are your habits?

Smoking	never	packs per day _____
Alcohol	never	drinks per day_____
Caffeinated Drinks	never	drinks per day_____
Exercise	never	times per week_____
Drug/Substance Abuse	never	Yes, if yes discuss with your doctor

MEDICAL HISTORY

Have you seen a doctor of chiropractic? Yes No

Who is your Family Physician:_____ Date of last physical exam:_____

Do you give us permission to send your family doctor your progress and treatment notes? Yes/No

Have you been hospitalized in the past five years? Yes No
Date and Reason: _____

Have you had any serious accidents in the past five years: Yes No
Date and Describe: _____

List your medications: _____

In the past 6 months have you suffered from: Circle all that apply or circle normal

General:	Fatigue	Weakness	Weight change	Loss of sleep	Normal
Neurological:	Headaches	Seizures	Dizziness	Nervousness	Normal
Eyes:	Vision trouble	Dryness	Redness	Cataract Glaucoma	Normal
Nose:	Pain	Bleeding	Sinus trouble	Infections	Normal
Mouth/Throat:	Sores	Bleeding	Enlarged Glands	Tonsillitis	Normal
Cardiovascular:	Coughing Palpitations	Sneezing Hypertension	Wheezing	Chest Pain	Normal
Gastrointestinal:	Diarrhea Constipation	Vomiting Gas	Appetite Change	Heartburn	Normal
Endocrine:	Goiter	Sugar in Urine	Heat Intolerance	Cold Intolerance	Normal
Psychologic:	Anxiety	Depression	Memory Loss	Mood Swings	Normal

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Have you ever had any of the following: Circle all that apply

Arthritis	Heart Trouble	Pacemaker
Diabetes	Dislocated Joints	Hay Fever
Asthma	Bone Fracture	Tuberculosis
Epilepsy	High blood pressure	Serious Injury
Allergies	Low blood pressure	Prostate Trouble
Sinus	Rheumatic Fever	Kidney Trouble
Scoliosis	Spinal Disease	Polio
Cancer	Thyroid Trouble	HIV
Ulcer	Sexually Transmitted Disease	AIDS

FAMILY HISTORY

Has any one in your family had any of the following: (if yes list relationship to patient)
Cancer:_____ Diabetes:_____
Heart Trouble: _____ High Blood Pressure: _____

Do any family members suffer from the following: please circle and list the relationship to you

Neck Problems: _____
Back Problems: _____
Headaches: _____
Arthritis: _____
Disc Problems: _____
Pinched Nerves: _____
Bad Posture: _____
Scoliosis: _____
Osteoporosis: _____

Doctor's Signature: _____

For Office Use Only: Height_____Weight_____
Pulse _____Blood Pressure_____

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AUTO ACCIDENT QUESTIONAIRE

Date of Accident: _____

Time of Accident: _____

To your knowledge what caused the accident? _____

What occurred following the accident? Circle all that apply

Received emergency care Felt confused Felt nervous

Loss of consciousness Felt weak Transported to the hospital via ambulance

After accident you were taken to? _____

Position in vehicle? Driver Front seat passenger Back seat passenger

Were you wearing a seat belt? Yes No

Was the accident: Expected Complete surprise

How was your vehicle struck? Front end Rear end Right side Left side

Did the air bags deploy? Yes No Did the seat break? Yes No

Did your vehicle have headrest? Yes No

What speed were you traveling? _____ What speed was other vehicle traveling? _____

What type of vehicle were you in? _____Type of other vehicle involved?_____

Was visibility (circle one) Poor Good

What was the condition of the roadway? Wet Dry other: _____

Where did you feel pain immediately following the accident? _____

Do you or did you have any visible abrasions? Yes No Where? _____

What type of treatment have you had since the accident? _____

_____.

Are you taking medication due to injuries from this accident? Yes No
If yes, what type of medication?_____

_____.

Where x-rays or special test performed following the accident? Yes No
If yes, list name or facility where tests were performed:_____

_____.

Do you have additional symptoms or complaints that have occurred since the accident? Yes No
If yes, please list: _____

_____.

Is there any additional information you would like us to know?

_____

_____

_____

_____

Doctor's Notes: _____

_____

_____

_____

_____

_____

Back & Body Chiropractic Center
Work Injury Questionnaire

Date of injury: _____

Time of injury: _____

Did you report this injury to your employer? Yes No Who did you report it to? _____

What caused the injury? _____

_____

Describe in your own words what happened? _____

_____

_____

_____

What is your major complaint? _____

_____

_____

Do you have any secondary complaints as a result of this accident? _____

_____

_____

Have you missed work due to this injury? Yes No How many days? _____

Describe your job duties: _____

_____

Additional information: _____

_____

Doctor's Notes: _____

_____