

Back-2-Back Chiropractic, P.C.

3000 NW Stucki Place, Suite 180

Hillsboro, OR 97124

T (503) 726-2225 F (503) 726-2224

Patient Health Intake Form

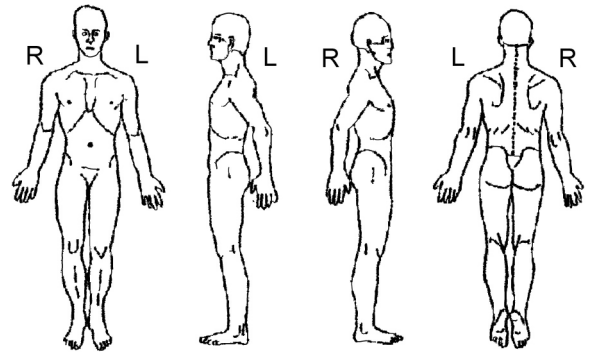
Confidential Data

Patient Name: _____ DOB: (m/d/y) _____ Age: _____ Date: _____

Give a brief, detailed description of the problem(s) you are experiencing: _____

Using the diagram and key, please draw where you are experiencing symptoms:

1. Achey, Dull, Sore
2. Stiffness, Tightness
3. Sharp Stabbing
4. Sharp Shooting
5. Numbness, Tingling
6. Burning
7. Throbbing
8. Swelling
9. Snapping, Popping, Grinding
10. Other: _____



When did the condition(s) start? _____ Onset of symptom(s) was: Immediate Gradual

Please describe what happened: (include related activities) _____

Is this condition related to: Employment? Yes No An auto accident? Yes No If so, has it been reported? Yes No

Your symptoms are: Constant - if constant, are they truly present 24hrs/day? Yes No
 Intermittent - if intermittent, how often do you feel them? _____ x/day How long do they last? _____
 - associated with any activities/positions/etc?

Compared to onset, are your symptoms: Better Worse Same

Do your symptoms prevent you from getting to sleep? Yes No Wake you at night? Yes No

Have you ever had this problem before? Yes No If so, please explain: _____

Please name your conditions/areas: 1: _____ 2: _____ 3: _____

Please rate the severity of your pain/symptoms: (0=no pain : 10=unbearable)

At Onset >>>	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Average >>>	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Percentage of time you experience symptoms: _____ % _____ % _____ %

What makes your condition(s) worse? (e.g. positions, activities, etc.) _____

What makes your condition(s) better? (e.g. positions, activities, heat/ice, medications, etc.) _____

Are your activities of daily living affected? (e.g. difficulty performing work duties, getting dressed, etc.) Yes No If so, please explain: _____

Please describe any other conditions/symptoms you feel are related to this complaint: _____

Have you ever been treated for this condition previously? Yes No If so, please complete below:

Date	Practitioner	Facility	Diagnosis	Treatment Provided

Please continue on the back...

Patient Name: _____ Date: _____

Please list any serious illnesses you have had: _____

Please complete the following table describing any hospitalizations or surgeries:

Date	Practitioner/Facility	Reason/Diagnosis	Treatment Provided

Please describe any major accidents/traumas/injuries you have had and the treatment received: _____

Please list any medications you are presently taking: (include vitamins)

Medication	Dose	Reason

Please list any allergies: _____

When was your last physical exam? _____

Any pertinent results? _____

Have you seen a chiropractor before? Yes No

If so, who? _____

What for? _____

Please describe any medical conditions that run in your immediate family: (e.g. heart disease, cancer, etc.; include siblings, parents, and grandparents)

Relative(s)	Conditions

Relative(s)	Conditions

Do you do any regular exercise? Yes No If so, please describe: (what, how much, how often) _____

Please describe your diet: _____

How often do you eat the following? (x/day or wk) _____ Fruits _____ Vegetables _____ Dairy _____ Meat _____ Sweets

How much water do you drink? _____ glasses/day

How much coffee? _____ cups/day

Do you drink alcohol? Yes No If so, how much? _____

Do you smoke? Yes No Packs/day: _____ How long? _____

How often do you have a bowel movement? _____ x/day or wk Recent Changes? Yes No Describe: _____

Any recent changes in bladder function? (freq, urgency, difficulty start/stop) Yes No Describe: _____

Women Only: Do you have a menstrual cycle? Yes No If so, when was your last cycle? _____

If not, please explain: _____

Are you presently on a contraceptive medication? Yes No If so, what? _____

Are you, or could you be pregnant? Yes No If so, estimated due date? _____

Patient Signature: _____

Date: _____

(parent/guardian if under 18)

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Patient Registration Form

Confidential Data

PERSONAL INFORMATION

Mr. / Mrs. / Miss / Ms / Dr.		/	/
Patient Name (first, middle initial, last)		Patient DOB (m/d/y)	Age
Patient Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	Email Address
Social Security #	Drivers License (State, Number)		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other		
Your Occupation	Your Employer		
Referred by:	<input type="checkbox"/> Friend	<input type="checkbox"/> Family Member	<input type="checkbox"/> Physician Name: _____
	<input type="checkbox"/> Website	<input type="checkbox"/> Advertisement	<input type="checkbox"/> Other: _____
Payment for Services will be by: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Health Insurance <input type="checkbox"/> Automobile Insurance <input type="checkbox"/> Workers Compensation			

INSURANCE INFORMATION

Name of Insurance Co.	Insurance Co. Phone Number		
Insurance Co. Address	City	State	Zip
Insurance Co. Policy #	Group #	Plan #	Policy Effective Date
Claim Rep. (if Auto Insurance)	Claim Rep. Phone Number/Ext.	Claim #	
Are you covered by more than one insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____			

PRIMARY CARE PHYSICIAN

Name of Physician	Name of Practice	Tel
Practice Address	City	State Zip

IN CASE OF EMERGENCY

Name of Relative or Friend	Relationship to Patient	Home Phone	Cell Phone
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The above information is true to the best of my knowledge. I authorize Back-2-Back Chiropractic to contact my insurance company as necessary and all benefits to be paid directly to Back-2-Back Chiropractic. I understand that I am responsible for any balance. I also authorize Back-2-Back Chiropractic or my insurance company to release any information required to process my claim.

Patient Signature (guardian if under 18)

Date