Back to Life Chiropractic

Confidential Patient Information

Name: _____ □ Mr. □ Mrs. □ Ms. □ Dr.
Last First MI

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: ____/____/_____ Social Security Number: _____

Occupation: _____ Employer: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

E-mail: _____ □ I would like to receive Back to Life's monthly newsletter.

Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □ Widow(er)

Children's Names/Ages: _____ Spouse: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____-_____

Person who referred you to our office: _____

Reason for today's visit: _____

Medical History

Please check all relevant conditions (past or present):

□ Heart Disease	□ Numbness/Tingling	□ Anemia
□ High Blood Pressure	□ Neuritis	□ Ear Aches/Infections
□ Diabetes	□ Hepatitis A B C (circle)	□ Hot Flashes
□ Nausea/Vomiting	□ Diarrhea	□ Constipation
□ Multiple Sclerosis	□ Asthma	□ Polio
□ Headaches	□ Concussion	□ Scarlet Fever
□ Cancer	□ Dizziness/ Faintness	□ Epilepsy
□ Digestive Disorder	□ Convulsions	□ Venereal Disease
□ Arthritis	□ German Measles/Rubella	□ Sinus Condition
□ Rheumatic Fever/Rheumatism	□ Muscular Dystrophy	□ Tuberculosis (TB)
□ Systemic Lupus Erythrathemia (SLE)	□ Alzheimer's Disease	□ Kidney Disease
□ Blurred or Tunnel Vision	□ Chronic Fatigue Syndrome	□ Fatigue
□ Stroke (Cerebrovascular Disease)	□ Chronic Obstructive Pulmonary Disease (COPD)	

List any other major illnesses or conditions past or present: _____
_____

Describe any major surgeries and year: _____

List any accidents or injuries (including auto accidents) and year: _____

Have you seen a physician for any other health condition(s) in the last year? □Yes □No

If "Yes", please describe condition(s): _____

Primary Care Physician (PCP): _____ PCP practice info: _____

Date of last physical exam: _____ PCP Contact number: (_____) _____-_____

Are you pregnant? □ Yes □ No If "Yes", how many months/weeks? _____

I clearly understand and agree that all services rendered me are charged directly to me and that I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend pr terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable. I agree to pay for ALL legal fees in collection proceedings are undertaken for my past due balance.

Patient Signature: _____ Date: ____/____/_____
If minor, please have parent/guardian sign.

Back to Life Chiropractic
Health and Stress Survey

Patient Name _____ Date _____

Circle the level of stress you are experiencing (1 as the lowest, 10 as unbearable):
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress: _____
(Change in job, work, home, family, finances, or legal problems)

Do you consider yourself: ☐Underweight ☐Overweight ☐Just right My weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? □ Yes □ No

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

_____

Do you experience any of these symptoms frequently (☐ E**very day** ☐ **3/more times per week**)?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation
☐ Chronic pain/inflammation	☐ Depression	☐ Panic attacks	☐ Nausea
☐ Fecal incontinence	☐ Bleeding	☐ Disinterest in sex	☐ Headaches
☐ Itching/rash Medical History	☐ Urinary tract infection	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever
☐ Arthritis-	☐ Allergies/hay fever	☐ Asthma	☐ Alcoholism
☐ Alzheimer's disease	☐ Autoimmune disease	☐ Bronchitis	☐ Cancer
☐ Chronic fatigue syndrome	☐ Cholesterol, elevated	☐ Dental problems	☐ Diabetes
☐ Blood pressure problems	☐ Circulatory problems	☐ Colitis	☐ Depression
☐ Carpal tunnel syndrome	☐ Diverticular disease	☐ Drug addiction	☐ Eating disorder
☐ Eyes/ears/nose/throat problems	☐ Epilepsy	☐ Emphysema	☐ Fibromyalgia
☐ Environmental sensitivities	☐ Food intolerance	☐ Genetic disorder	☐ Glaucoma
☐ Gastroesophageal reflux disease	☐ Infection, chronic	☐ Mental illness	☐ Mental retardation
☐ Inflammatory bowel disease	☐ Gout	☐ Heart disease	☐ Tuberculosis
☐ Irritable bowel syndrome	☐ Learning disabilities	☐ Migraine headaches	☐ Sinus problems
☐ Kidney or bladder disease	☐ Thyroid trouble	☐ Osteoporosis	☐ Ulcer
☐ Liver/gallbladder disease	☐ Obesity	☐ Vomiting	☐ Stroke
☐ Liver/gallbladder stones	☐ Skin problems	☐ Varicose veins	☐ Pneumonia
☐ Neurological issues	☐Parkinson's	☐ Nervousness	
☐ Sexually transmitted disease	☐ Seasonal affective disorder		

☐ Other: _____

Medical (Women)

☐ Pelvic inflammatory disease	☐ Endometriosis	☐ Infertility	☐ Menstrual irregularities
☐ Sexually transmitted disease	☐ Breast cancer	☐ Decreased sex drive	☐ Vaginal infections
☐ Premenstrual syndrome (PMS)	☐ Fibrocystic breasts	☐ Fibroids/ovarian cysts	

☐ Other: _____

Date of last GYN exam _____ Mammogram ☐ + ☐ — PAP ☐ + ☐ —
Form of birth control _____ Number of children _____
Number of pregnancies _____ ☐ C-section _____
Age of first period _____ Date of last menstrual cycle _____
Length of cycle _____ days Interval of time between cycles _____days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
☐ Surgical menopause ☐ Menopause ☐ Hysterectomy _____

Back to Life Chiropractic
Health and Stress Survey

Patient Name _____ Date _____

Medical (Men)

☐ Benign prostatic hyperplasia (BPH) ☐ Prostate cancer ☐ Decreased sex drive
☐ Sexually transmitted disease ☐ Infertility ☐ Other: _____

Family Health History (Parents and Siblings)

☐ Arthritis	☐ Asthma	☐ Alcoholism	☐ Alzheimer's disease
☐ Cancer	☐ Depression	☐ Diabetes	☐ Drug addiction
☐ Eating disorder	☐ Genetic disorder	☐ Glaucoma	☐ Heart disease
☐ Infertility	☐ Learning disabilities	☐ Mental illness	☐ Mental retardation
☐ Migraine headaches	☐ Neurological disorders (Parkinson's, paralysis)		☐ Obesity
☐ Osteoporosis	☐ Stroke	☐ Suicide	

☐ Other: _____

Health Habits

List the frequency of use: *(Circle)* *(Circle)*

Cigarettes _____ packs day/week/month Tobacco produces _____ day/week/month
Alcoholic drink(s) _____ day/week/month Recreational drugs _____ day/week/month
Beer (12 ounces) Wine (6 ounces) Liquor (1.5 ounces)

Caffeine ☐ Coffee (cups) _____ ☐ Tea: cups _____ ☐ Soda: (12 ounce cans) _____
Exercise ☐ 5-7 days per week ☐ 3-4 days per week ☐ 1-2 days per week workout
☐ 30-45 minutes per workout ☐ Less than 30 minutes ☐ Walk days/wk _____
☐ Aerobic days/wk _____ ☐ Weight lift days/wk_____ ☐ Stretch days/wk_____
☐ Other _____

Nutrition & Diet

☐ Mixed food diet (animal and vegetable sources) ☐ Vegetarian ☐ Vegan
☐ Salt restriction ☐ Fat restriction ☐ Starch/carbohydrate restriction
☐ The Zone Diet ☐ Total calorie restriction ☐ Specific food restrictions:
☐ Dairy ☐ Wheat ☐ Eggs ☐ Soy ☐ Corn ☐ All gluten ☐ Other _____

Food Frequency Number of servings per day:

Fruits (citrus, melons, etc.) _____ ☐ Dark green or deep yellow/orange vegetables _____ ☐ Dairy, eggs_____
☐ Grains (unprocessed) _____ ☐ Beans, peas, legumes _____ ☐ Meat, poultry, fish _____

Eating Habits

☐ Skip meals - which ones _____ ☐ One meal/day ☐ Two meals/day ☐ Three meals/day
☐ Graze (small frequent meals) ☐ Generally eat on the run ☐ Eat constantly whether hungry or not

Current Supplements

☐ Multivitamin/mineral ☐ Vitamin C ☐ Vitamin E ☐ EPA/DHA ☐ Calcium, source _____
☐ Digestive enzymes ☐ Amino acids ☐ Antioxidants (e.g., lutein, resveratrol, etc.) ☐Protein shakes
☐ Homeopathy ☐ Herbs ☐ Super foods (e.g., bee pollen, phytonutrients)
☐ Liquid meals (Ensure) ☐ Other _____ _____

Desired Health Goals

☐ Feel more vital	☐ Have more energy	☐ Have more endurance	☐ Be less tired after lunch
☐ Sleep better	☐ Be free of pain	☐ Get less colds and flu	☐ Get rid of allergies
☐ Stop using laxatives/stool softeners		☐ Improve sex drive	☐ Better muscle tone
☐ Lose weight	☐ Be stronger	☐ Be more flexible	☐ Reduce stress level
☐ Think more clearly/be mentally focused		☐ Improve memory	☐ Be less depressed
☐ Feel more motivated	☐ Be less moody	☐ Be less indecisive	☐ Slow down accelerated aging
☐ Reduce my risk of degenerative disease		☐ Maintain a healthier life longer	

☐ Change from a "treating-illness" orientation to creating a wellness lifestyle
☐ To not be dependent on over-the counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.

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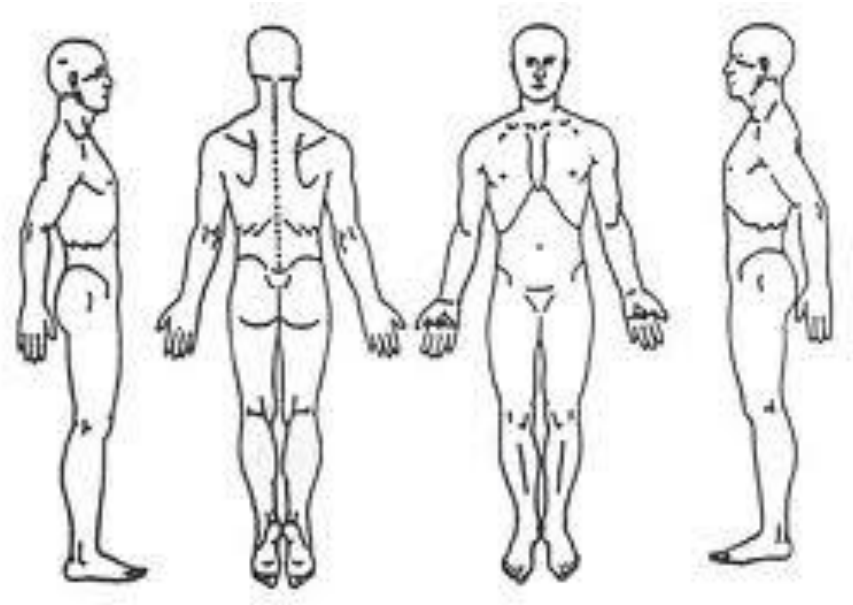
Pain Diagram

Patient Name _____ Date _____

Please use the figures below to identify your current pain or complaint.



Please use the symbols below to indicate symptoms:	
Ache	^ ^ ^ ^ ^
Burning	= = = = =
Numbness	O O O O
Pain	X X X X
Pins and Needles	. . . . .
Stabbing	/ / / / / / / /
Other	+ + + + + +

Rate your **current** pain intensity by marking an "**X**" on the scale at the position that represents it.

NO PAIN WORST IMAGINABLE

0 1 2 3 4 5 6 7 8 9 10

_____

Rate your pain intensity at its **worst** by marking a "W" on the scale at that position.

NO PAIN WORST IMAGINABLE

0 1 2 3 4 5 6 7 8 9 10

_____

Rate your pain intensity at its **best** by marking a "**B**" on the scale at that position.

NO PAIN WORST IMAGINABLE

0 1 2 3 4 5 6 7 8 9 10

_____