BACK ON TRACK
CHIROPRACTIC
& WELLNESS
CENTER
The Road To Better Health

ABOUT THE PATIENT

Name _____ Today's Date_____ DOB _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender M F

Significant Other's Name _____ Have you been to a chiropractor before? □ No □ Yes

Your Employer _____ Type of Work _____

e-Mail Address _____ Social Secuirty #_____

How did you hear about us?_____Were you referred? Yes No Who referred you to us?_____

Emergency Contact _____ ph # _____

Please carefully read and initial below:

_____ I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.

_____ I authorize Back on Track Chiropractic to release and / or request records to or from other providers as may be necessary.

_____I understand I am responsible for all bills incurred in this office.

_____I authorize assignment of my insurance benefits (if applicable) directly to the provider.

_____I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____I understand and agree to pay the No Show $25 fee for appointments not cancelled or rescheduled within 24 hours of scheduled time.

_____ _____

Patient Name (Print and Sign) (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

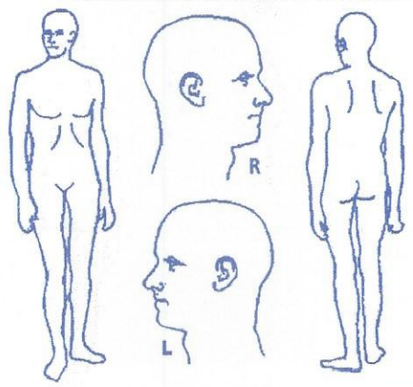
1. _____ **How long has this been an issue?** _____
   Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
   Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____
2. _____ **How long has this been an issue?** _____
   Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
   Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____
3. _____ **How long has this been an issue?** _____
   Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
   Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____
4. _____ **How long has this been an issue?** _____
   Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
   Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to_____
5. **Does your condition affect:** Sleep Work Daily Routine Sitting Driving
6. **What makes it better?**_____
7. **What makes it worse?** _____
8. **What Doctor's have you seen for this?**_____
   _____
9. **Type of treatment:**_____
10. **Results:** _____

NOTES: _____

_____

_____

Please mark all areas of concern.



Are you pregnant?

Yes No

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GENERAL HEALTH HISTORY

Patient Name_____ ***Circle the condition(s) that apply to you.***

Headaches
Migraines
Shortness of Breath
Allergies / Asthma
Medication Side Effects
Diabetes
Hands or Feet cold
Muscle aches
Trouble Walking
Leg / Foot Numbness
Fainting
Gall Bladder Trouble
Ringing in Ears
Ear Problems
Sleeping Problems
Vision Problems
Thyroid Problems
Liver Disease
Kidney Problems
Light Bothers Eyes

Urinary Problems
Easy Bruising
Tobacco Use
Dental Problems
Fibromyalgia
Blood Thinner use
HIV Positive
Cancer
Depression
Alcohol Use
___High or ___Low Blood Pressure
Stroke History
High Cholesterol
TMJ
Digestive Problems
Pain all Over
Tension / Irritability
Chest Pains
Heart Pacemaker
Heart Problems

Other _____

1. **List any medications you are taking:**_____
2. **Please list all doctors you are currently seeing:** _____
3. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** No Yes , Name_____

PAST HISTORY

4. **List any past auto collisions:**_____ **Was any care received?**_____
5. **List any past work injuries:** _____ **Was any care received?**_____
6. **List any past sport, recreational, or home injuries**_____
7. **Please describe any past conditions and treatment received:** _____
8. **Please list any past hospitalizations and surgeries:** _____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Is there any other family history you want us to know?_____