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

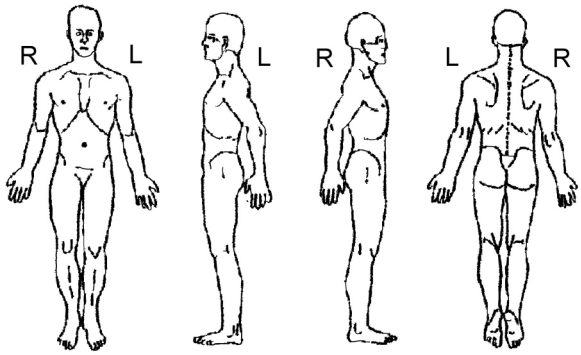
Patient Name: _____ **DOB:** (m/d/y)_____ **Age:** _____ **Date:** _____

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:_____

		1:	2:	3:
Please name your conditions/areas:				
Please rate the severity of your pain/ symptoms: (0=no pain : 10=unberable)	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 : ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other

Your Occupation _____ Your Employer _____

Referred by: ❑ Friend ❑ Family Member ❑ Physician Name: _____

❑ Website ❑ Advertisement ❑ Other: _____

Payment for Services will be by: ❑ Cash ❑ Check ❑ Credit Card ❑ Health Insurance ❑ Automobile Insurance ❑ 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? ❑ No ❑ 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 _____

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 _____