Welcome to the Back and Neck Care Center

PERSONAL INFORMATION: Today's Date: _____

Name: _____ Birth date: _____ Age: ____ Sex: M / F

Address: _____ City: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Marital Status: S M D W #Children: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Female: Are you pregnant? Yes No Unsure

Have You Had Chiropractic Care? Yes No Doctor Name & Date of Last Visit: _____

Emergency Contact: _____ Phone Number: _____

Who referred you or how did you hear about us? _____

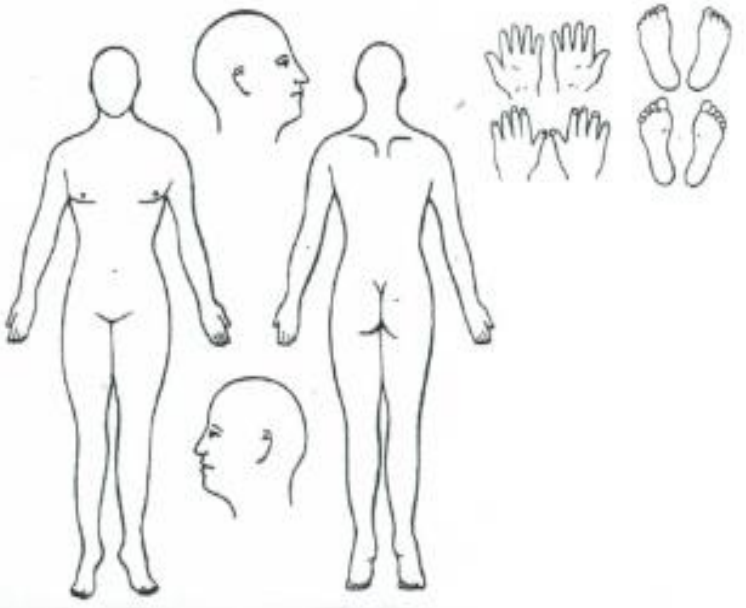
TELL US WHERE YOU HURT

What is your major complaint? _____

When did this begin? _____ Is This a Work Injury? ____ Auto Injury? ____

Please draw the location, type of pain and the level of discomfort on the diagram below.
If your pain radiates, draw an arrow from where it starts to where it stops.

^^^^ Ache
==== Burning
ooo Numbness
:::::: Pins and Needles
////// Stabbing
xxx Other



0 1 2 3 4 5 6 7 8 9 10
(No pain) mild uncomfortable distressing Intense unbearable

Name: _____ **Date:** _____

How often are symptoms present? (occasional) 0-25% 26-50% 51-75% 76-100% (constant)
Other doctors seen for this condition? _____
Have you had spinal X-rays, MRI or CT scan for your areas of complaint? Yes No
Dates: _____ What areas? _____
Have you ever had the same or similar condition? Yes No Please Explain: _____
Have you been treated for any health problems in the last year? Yes No
If yes, please explain: _____

Check all **activities that cause discomfort:**

___ walking
___ standing
___ sitting
___ exercise
___ driving
___ lying down
___ work
___ dressing
___ household chores
___ lifting/carrying
___ bending
___ climbing stairs
___ pushing or pulling
___ coughing/sneezing
___ recreational activities
___ other: _____

HABITS:	HEAVY	MODERATE	LIGHT	NONE
Coffee	_____	_____	____	_____
Alcohol	_____	_____	____	_____
Tobacco	_____	_____	____	_____
Drugs	_____	_____	____	_____
Sugar	_____	_____	____	_____
Exercise	_____	_____	____	_____
Water	_____	_____	____	_____

Sleeping Position: ( ) Back ( ) Side ( ) Stomach

Please check all **medications you are currently taking**: (*Prescription and over the counter*)

___ blood pressure
___ diabetes
___ cholesterol
___ pain killers
___ muscle relaxers
___ birth control pill
___ anti depressants/anxiety
___ anti inflammatory/NSAIDS
___ steroids/prednisone
___ other: _____

Since The Pain Started: (*have you had any of the following?)*

___ fevers/chills
___ dizziness
___ diarrhea
___ fatigue
___ headaches
___ blood in urine
___ ringing in ears
___ pain at night
___ coughing up blood
___ nausea/vomiting
___ numbness
___ visual disturbances
___ swelling or cold hands/feet
___ change in bowel or bladder control

Accident History: _____
Surgical History: _____
Fractures/Broken Bones: _____

Past Conditions: (*have you ever had any of the following?*)

___ anemia
___ arthritis
___ asthma
___ cancer
___ diabetes
___ digestive disorders
___ bladder/urinary problems
___ kidney problems
___ high blood pressure
___ osteoporosis
___ stroke/TIA
___ seizures
___ hepatitis
___ HIV/AIDS
___ other: _____
___ prostate problems
___ menstrual problems
___ thyroid problems
___ rheumatic fever

Family History: (*have any members of your family had any of the following?)*

___ cancer
___ diabetes
___ stroke/TIA
___ heart disease
___ high blood pressure
___ rheumatoid arthritis

CONSENT FOR TREATMENT:

I hereby authorize consent to **The Back and Neck Care Center** to provide medical care and treatment to myself or my minor child.

PRINT: _____ *SIGN:* _____ *DATE:* _____
Patient or Legal Guardian Patient or Legal Guardian

INSURANCE INFORMATION:

Are You Insured? Yes No Auto Accident? ____ Work Injury? ____ Health Savings Acct? Yes No

Full Name of Policy Holder: _____ Policy Holder's DOB: _____

Primary Insurance Co: _____ Policy #: _____

Secondary Insurance Co: _____ Policy #: _____

Policy Holder's Employer: _____ Phone #: _____

AUTHORIZATION & RELEASE:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers, attorneys and/or other health practitioners.

I authorized and request my insurance company to pay directly to **The Back and Neck Care Center**, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents.

PRINT: _____ *SIGN:* _____ *DATE:* _____
Patient or Legal Guardian Patient or Legal Guardian

Notice of Privacy Practices Acknowledgment
The Back and Neck Care Center

I understand that under the Health Insurance Portability and Accountability Act(HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____
Patient Name or Legal Guardian(Print) Date

_____
Signature