BACK to BASICS

PATIENT INTRODUCTION FORM

Today's Date: _____, 20_____
Name: _____ SS#_____
Address: _____ Apt#_____ Date of Birth: ___/___/_____
City: _____ State: _____ Zip: _____ Gender: **(M) (F)**
Cell (_____) _____ WK (_____) _____ HM (_____) _____
Occupation: _____ Employer: _____
EMAIL: _____ Marital Status **(M) (S) (D) (W) (O)**
Women: Are you pregnant**(Y) (N)** Number of Children: ____
Spouse's Name: _____ *Phone: (_____)* _____
Activities/Sports/Hobbies: _____
How did you hear about us? **(Google) (Yelp) (Existing patient) (Other)** Explain: _____
Have you seen a Chiropractor before? **(Y) (N)**

IN CASE OF EMERGENCY

Contact Name: _____Phone: (_____) _____Relationship:_____
Primary Care Physician: _____ Office Phone: (_____) _____

MEDICAL HISTORY

(Check all that apply, past or present symptoms)

__Headaches
__High Blood Pressure
__Leg Cramps
__Weakness of Limbs
__Allergies
__Stress
__Joint Pain
__Neck Pain
__Lower Backaches
__Fatigue (AM) (PM)
__Asthma
__Dizziness
__Upper Backaches
__Nervousness
__Digestive Problems
__Stiff Neck

When did you symptoms begin? _____
Briefly describe your symptoms:_____
How did your symptoms start?_____
Pain Level **(1-best) (2) (3) (4) (5) (6) (7) (8) (9) (10-worst)**
How often do you experience your symptoms? **(1)Constantly (2)Frequently (3)Occasionally (4)Intermittently**
How do your symptoms interfere with daily activities?**(1)Not at all (2)A little bit (3)Moderately (4)Quite a bit (5)Extremely**
In general, how would you say your current overall health is **(1)Excellent (2)Very Good (3)Good (4)Fair (5)Poor**
Are you taking any medications? List: _____
Are you taking any supplements? List: _____
List any accidents/traumas/surgeries: _____
Is there a family history of: Cancer Heart Disease Diabetes Other:_____
Do you have health insurance? **(Y)(N)** Company?_____
Insurance Customer Service # (____) _____Policy ID# _____ Grp#_____

I have read carefully and agree to the terms of the Financial and Cancellation Policy, Informed Consent and Terms of Acceptance of Back to Basics. I also agree to the terms that I am the said responsible party for my own payments due in receipt for my treatment with Back to Basics.

_____ _____
Patient Name Printed Patient Signature Date

If patient is a minor: I hereby give my consent and permission for _____ to be treated in this office and furthermore agree to the above aforementioned.

_____ _____
Guardian Name Printed Guardian Signature Date