Back to Wellness Clinic - New Patient Form Chart#_____

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

What number do you prefer we reach you at? □ Home □ Cell

Date of Birth: _____ Age _____ Social Security #: _____-_____-_____

Gender: □ Male □ Female Marital Status: □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced

Email Address: _____ Occupation: _____

Employer/School _____ City/St. _____

Spouse's Name: _____ Spouse's # _____

Whom may we thank for referring you: _____

****

IN CASE OF EMERGENCY, CONTACT:

Name _____Relationship _____

Phone # _____

INSURANCE:

Who is responsible for this account: _____ Relation to patient: _____

Name of Insurance Company: _____

Policy #: _____ Group #_____

Name 2nd Insurance Company (if applicable): _____

Policy #: _____ Group #_____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of company) And assign directly to Dr. Michael Hughes or Dr. Haley Lance all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, or Personal Representative **Please print name of Patient, Parent or Personal Representative**

_____ _____

Date **Relationship to Patient**

Patient Intake Form

Patient Name _____Date _____ Chart #_____

List any Allergies:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin □ Ragweed/Pollen

□ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye □ Other: _____

List any Surgeries and year:

□ Back ___ □ Brain ___ □ Elbow ____ □ Foot ____ □ Heart ____ □ Hip ____ □ Knee ____ □ Neck ____

□ Neurological _____□ Shoulder ____ □ Wrist/Hand ____ □ Other: _____

List **ALL Past Medical History** conditions:

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Depression

□ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting □ Fatigue □ Foot Pain

□ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ High Blood Pressure

□ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Menstrual Problems □ Mid-Back Pain

□ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems □ Pacemaker □ Parkinson's

□ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Sprain/Strain

□ Stroke/Heart Attack □ Other: _____

List all Medications you are currently taking: (Example: Ibuprofen – Pain)

_____ _____

_____ _____

_____ _____

Are you allergic to any medications: □ No □Yes _____

List your Family History: Mother/Father/Brother/Sister Only

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio

□ Prostate Problems □ Stroke/Heart Attack

Please list all family members who had/has any of the problems above: Example: Sister – Diabetes

_____ _____

_____ _____

_____ _____

Have you had any auto or other accidents in the past? □ No □Yes When? _____

Describe: _____

What was date of last physical examination: _____

How would you rate your overall heath? □ Very good □ Good □ Fair □ Poor

Do you smoke? □ No □Yes –How many per day? _____ If no were you a former smoker? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____ Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

What activities do you enjoy outside of work? _____

Patient Name _____Date _____ Chart#_____

Have you ever had chiropractic care? □ Yes □ No Where? _ _____

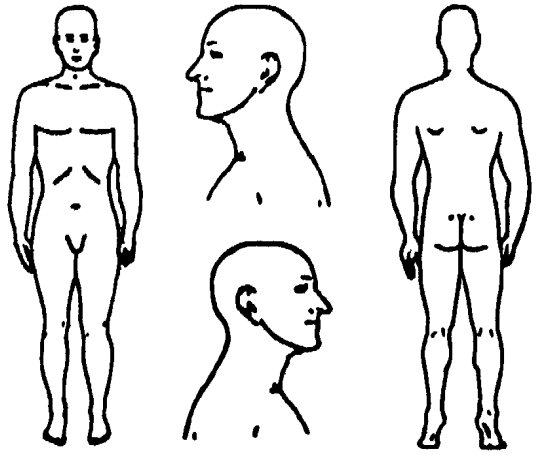
Why? _____ When was your last visit? _____

Were X-Rays taken? □ Yes □ No

Is your current complaint due to a fall or accident/auto accident? _____ If so, date of accident? _____

Describe: _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- □ **Become pain free**
- □ **Explanation of my condition**
- □ **Learn how to care for my condition**
- □ **Reduce symptoms**
- □ **Resume normal activity level**

<u>What is your FIRST (primary) complaint</u>? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Patient Name _____Date _____ Chart#_____

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

If needed:

What is your NEXT complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

□ Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

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What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

_____

Signature of Patient, Parent, or Personal Representative **Revised 8/30/18.cr**