Back to Wellness Clinic - Patient Update

Date _____Chart#_____

Name _____

Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Preferred way to reach you? □ Home □ Cell

Date of Birth: _____ Email Address: _____

Emergency Contact: _____ # _____ Relationship _____

List any **Allergies**:

_____

List any **Surgeries over the past 3 years and when**: (Example: Gall bladder - 03/2020)

_____

_____

List **recent medical** conditions:

_____

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

_____ _____

_____ _____

_____ _____

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

List your Family History:

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

□ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Stroke/Heart Attack

Please list all family members who had/has any of the problems above: Example: Mother/Father/Sibling – High blood pressure

_____ _____

_____ _____

_____ _____

Have you had a recent car accident? □ No □Yes Have **you had any recent falls?** □ No □Yes

If fall/accident Describe and when: _____

_____

Did you seek medical attention? □ No □Yes Where: _____

What was date of last physical examination: _____

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

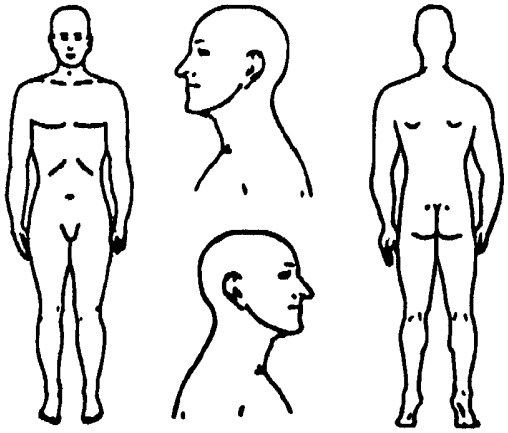
Do you drink alcohol? □ No □Yes - how many per week? _____

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

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

Patient Name _____ Date _____ Chart#_____

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**

What is your FIRST (primary) 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 the pain from 1-10: At its worst_____ At the present time_____ At least severe_____

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)? _____

****Insurance card - Please give card to the front desk, so they can make a copy. ****

Insurance Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Michael Hughes
Name of Insurance Company

Dr. Jennifer Carter, Dr. Brian Bunge 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 benefits 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 Rep.**

_____ _____

Date **Relationship to Patient**

********************I authorize Back to Wellness to send appointment reminders: (Initial) _____ ********************

Cell phone # _____ Email_____R-1.9.20