Back To Health Chiropractic

Patient Registration

Patient Information

Date_____

Patient Name:_____
Last Name

_____ _____
First Name Middle Initial

Nickname:_____

Address:_____

City:_____

State_____ Zip_____

Sex: □ M □ F Age_____

Birth Date_____
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Occupation_____

Employer/School_____

Employer/School Phone (_____) _____

Spouse's Name_____

Spouse's Birth Date_____

Spouse's Employer_____

Do you have Children? □No □Yes

How many?_____

How did you hear about us?
□ Internet □ Sign □ Insurance company
□ Referred by _____ □ Other _____

Contact Information

Home Phone (_____) _____

Cell Phone (_____) _____

Cell Provider_____

Email _____
Preferred method of contact: □ Home Phone □ Cell
□ Email □ Text

Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT
Name_____ Relationship_____

Phone (_____) _____

Financial Information

Who is responsible for this account? _____

Will you be using insurance to help pay for your care? □ Yes □No
If yes, please complete the following:

Name of insured person _____

Relationship to Patient _____

Insurance Co. _____

Member ID # _____

Is patient covered by additional insurance? □ Yes □ No

Subscriber's Name _____

Birth Date _____

Relationship to patient _____

Insurance Co. _____

Member ID #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. Derek Carroll all insurance benefits, if an, 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.
Dr. Carroll and/or his staff may use my health care 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, guardian, or personal representative

_____
Please print name of patient, parent, guardian, or personal representative

_____ _____
Date Relationship to patient

Accident Information

Is condition due to an accident? □ Yes □ No Date_____
Type of accident: □ Auto □ Work □ Home □ Other_____
To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney name (if applicable) _____

Last:_____First:_____ File #_____

PATIENT INTAKE FORM

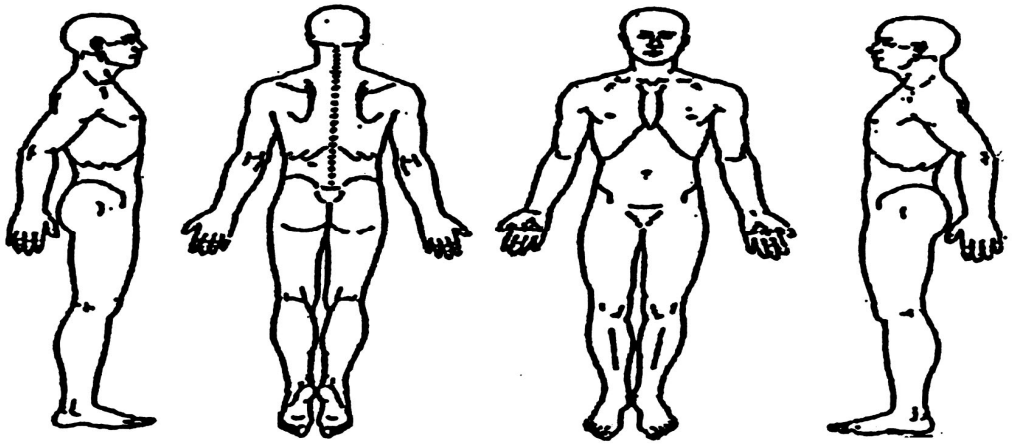
Patient Name: _____ Date: _____

- **Are you here today for: □ Wellness/Health Optimization □ Maintenance/Injury prevention □ An active complaint**

- **If here for an active complaint, please describe** _____

_____

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

9. How long have you had this problem? _____

10. How do you think your problem began?

_____

Last:_____First:_____ File #_____

11. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

12. What aggravates your problem?
_____

13. What relieves your symptoms?
_____

14. What concerns you the most about your problem; what does it prevent you from doing?
_____

15. What is your: Height_____ Weight _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Benign Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

- **What medications you are currently taking (including all non-prescription drugs):**
  _____
- **List any vitamins or supplements you are currently taking:**
  _____
- **List all surgical procedures you have had:**
  _____

Last:_____First:_____ File #_____

- **What activities do you do at work/school?**

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Drive:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Misc:**	□ Do manual labor	□ Read a lot	□ Travel frequently

- **What activities do you do outside of work/school?**
  _____

  _____

- **Have you ever been hospitalized?** □ No □ Yes
  if yes, why _____

- **Have you had any significant past trauma?** □ No □ Yes
  If yes, please describe _____

  _____

- **When was your last chiropractic visit?** _____
- **Anything else pertinent to your visit today?**_____
- **Please complete the following questions:**
  - If I had 15% better function, I would be able to _____

    _____.
  - If I could do one thing to improve my health, it would mean_____

    _____ to me.
  - If I could foster better health in my kids, it would mean _____

    _____.
  - The one thing that I want to be able to continue to do from now until the end of my life is
    _____

    _____.

Patient Signature_____ **Date:**_____