Back on Track Chiropractic

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Phone (231) 922-0421 www.backontrackmi.com

Please fill out this form as completely and accurately as possible.

Today's Date _____ Patient File # _____

PERSONAL DATA

Name_____ Age _____ Date of Birth _____
Parents' names (if you are under 18) _____
Home Address_____ City _____ State_____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ E-Mail Address_____
Occupation_____ Employer _____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name:_____
Names and ages of children _____
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Corrective Care Chiropractic can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work/School Y N	Driving Y N	Sleep Y N	Eating Y N
Exercise/sports Y N	Walking Y N	Sitting Y N	Other Y N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑N Name of D.C._____

How long under care? ❑_____ days ❑_____ weeks ❑_____ months ❑_____ years

Date of last visit: _____Why did you stop?

_____

How was your experience?_____

Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)

❑Medical Physician ❑Naturopath ❑Acupuncturist ❑Homeopath ❑Massage Therapist ❑Psychotherapist

❑Energy Healer ❑Dentist Reason why: _____

PAST PHYSICAL TRAUMAS

Were you born at home or in a hospital? Medication used? ❑Y ❑N C-section? ❑Y ❑N Forceps/vacuum? ❑Y ❑N
Did you have any **significant childhood or adult injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

_____

Have you had any **automobile accidents or work-related injuries**?
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

_____

Does your job require regular airline travel and hotel stays? ❑Y ❑N If yes, how often? _____
How long is your daily commute? _____ How many hours do you typically work in a week? _____
How many hours per week do you watch T.V.? ____ Are you sitting or lying on a couch? _____
Please describe your exercise/sports program including type and frequency:

_____

_____

How many hours of sleep do you typically get each night? _____ Do you sleep well? ❑Y ❑N
Do you ever sleep on your stomach? ❑Y ❑N How old is your mattress? _____
Do you wear orthotics (foot supports) or a heel lift? ❑Y ❑N If yes, for how many years? _____
Do you use a cervical pillow? ❑Y ❑N

EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	❑Y ❑N	Loss of loved one	❑Y ❑N	Abuse	❑Y ❑N
Work or school	❑Y ❑N	Divorce/separation	❑Y ❑N	Financial	❑Y ❑N
Lifestyle change	❑Y ❑N	Parents divorce	❑Y ❑N	Illness	❑Y ❑N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.)
The following will reveal exposures you may have had.
Were you **vaccinated?** ❑Y ❑N If yes, did you have a **reaction**? ❑Y ❑N
Have you been **exposed to** any of the following on a regular basis, past or present?
❑ Toxic chemicals ❑Radiation ❑Second hand smoke ❑Chemotherapy ❑Drug therapy ❑Other
If yes, please explain:_____
Do you have any **food allergies**? ❑Y ❑N **If yes, please list:** _____

_____

How many **fast food meals** do you eat per week? _____
How many **alcoholic beverages** do you drink per week? _____
Do you smoke **tobacco products**? ❑Y ❑N If yes, how many packets per day? _____
Have you smoked **tobacco products** in the past? ❑Y ❑N
How many glasses of **water** do you drink per day? _____
How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____
Are you currently on **prescription** or **over-the counter medication?** ❑Y ❑N Please list, indicating dose & frequency_____

_____

Please list any **nutritional supplements** you are taking: _____

_____

How do you rate your **physical health**? ❑Excellent ❑Good ❑Fair ❑Poor

FOR WOMEN ONLY

Are you pregnant? ❑Y ❑N Possible/Unknown
If pregnant due date?_____ Name of OBGYN or Midwife:_____
If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.
Signature:_____ Date:_____

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

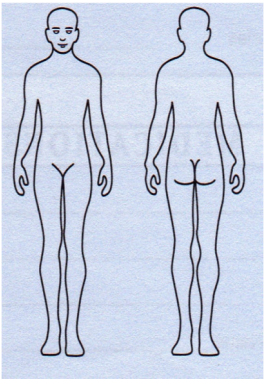
Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms, or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

Primary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram.
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram to the left.
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____

Office Use Only:

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)
_ Relief of a symptom or problem
_ Relief and prevention of a symptom or problem
_ Healthier spine and nerve system
_ Optimal health on all levels
What are your top three health goals?
1. _____
2. _____
3. _____
I hereby certify that the information provided is true and accurate.
Patient Signature: _____ Date: _____

WEBSITE SUBSCRIPTION

Email _____

If you would like, we can use your email to send you office information like changes to office hours or unexpected closings and also send occasional health related emails. Please check the appropriate box to indicate what level of communication you would like.

❑ I would like to receive both office information and health related emails.

❑ I would prefer to only receive emails about office information (office closings, changes to hours, etc.)

ELECTRONIC HEALTH RECORD

If you would like to have your records from this office available online, please fill out this additional information and initial in the space provided. If you would prefer not to, please write opt out in the initial space provided.

_____ **I hereby give my consent to have my health records available to me via a secure web-based portal.**
(Please Initial)

Ethnicity ❑ non-Hispanic ❑ Hispanic ❑ Decline to specify

Race ❑ Caucasian ❑ African American ❑ Native American ❑ Hawaiian/Pacific Islander

❑ Other _____ ❑ Decline to specify

Preferred Language ❑ English ❑ Spanish ❑ Other _____

Height _____

Please list all prescription medications <u>including dosage:</u>
_____
_____
_____

Are you allergic to any medication? ❑ Yes ❑ No
**If yes, please list the medications you are allergic to and the reaction you experience.*
_____
_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I acknowledge that Back on Track Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand that I have a right to review Back on Track Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Back on Track Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practices for Back on Track Chiropractic is also provided on request at the main administration desk of this practice and on Back on Track Chiropractic's website at www.backontrackmi.com.

Back on Track Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Back on Track Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative Date

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority