Back To Life Chiropractic
4045 East Bell Rd, Suite 107
Phoenix, AZ. 85032
Office: (480) 703-1834

PATIENT INFORMATION

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Birthdate ____/____/____ Age_____

SS#_____

E-mail_____

Address _____

City_____

State_____Zip_____
Sex ☐ M ☐ F
☐ Married ☐ Widowed ☐ Single
☐ Separated ☐ Divorced ☐ Minor
Occupation/Employer _____
Spouse's Name _____
Spouse's Birthdate _____
Spouse's Employer_____
Names & ages of children_____
How were you referred to this office?_____

INSURANCE INFORMATION

Primary Insurance Co. _____
Subscriber's Name_____
Relationship to patient _____
Subscriber's Birthdate _____
Subscriber's SS# _____
Subscriber's Address _____
_____
Subscriber's employer _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Secondary Insurance Co. _____
Subscriber's Name_____
Relationship to patient _____
Subscriber's Birthdate _____
Subscriber's SS# _____
Subscriber's Address _____
_____
Subscriber's employer _____

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Back To Life Chiropractic and Wellness. 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 name doctor 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 treatment plan is completed.

Signature of patient/parent _____

Print name of patient/parent_____

PHONE NUMBERS

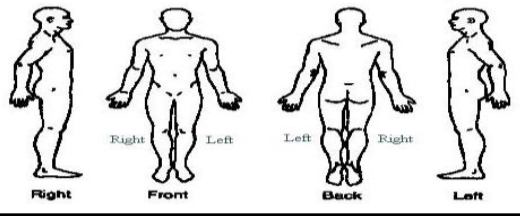
Home # _____Cell # _____
Best time & place to reach you_____
In case of emergency contact_____
Home #_____Cell #_____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date:_____
Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other
To who have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

PATIENT CONDITION

Reason for this visit _____
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)
How would you describe the type of pain?
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
☐ Diffuse ☐ Shooting w/motion ☐ Stabbing w/ motion ☐ Electric like w/ motion ☐ Other:_____
How are your symptoms changing with time?
☐ Getting worse ☐ Staying the Same ☐ Getting Better
Indicate on the drawings below where you have pain/symptoms:



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PATIENT CONDITION *CONTINUED*

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)
How much has the problem interfered with your work?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
How much has the problem interfered with social activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
Who else have you seen for your problem?
☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician ☐ ER physician ☐ Orthopedist
☐ Massage Therapist ☐ Physical Therapist ☐ Other:_____ ☐ No one
How long have you had this problem?_____
How do you think your problem began?_____
Do you consider this problem severe?
☐ Yes ☐ Yes, at times ☐ No
What aggravates your problem?_____
What concerns you the most about your problem; what does it prevent you from doing? _____
_____
Weight_____ Age_____
Have you seen a chiropractor before? ☐ Yes ☐ No Who?_____
When?_____
Reason for visits?_____ How did you respond?_____
Did you know that your posture determines your health? ☐ Yes ☐ No
Are you aware of poor postures in you, your spouse, or your children? ☐ Yes ☐ No Explain_____
The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward, weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health.
Have you ever been told or feel that you carry your head forward? ☐ Yes ☐ No
How would you rate your overall health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
What type of exercise do you do?
☐ Strenuous ☐ Moderate ☐ Light ☐ None
Indicate if you have any immediate family members with any of the following:
☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Heart Problems
☐ Cancer ☐ ALS
List all prescription medications you are currently taking:_____
_____
List all of the over-the-counter medications, herbs, vitamins, minerals, or supplements you are currently taking:_____
_____
List all surgical procedures you have had:_____
_____
What activities do you do at work?
☐ 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 the day ☐ A little of the day
What activities do you do outside of work? _____
_____
Have you ever been hospitalized? ☐ No ☐ Yes If yes, why? _____
Have you had significant past trauma? ☐ No ☐ Yes If yes, describe _____
_____
_____
_____

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Please check any health conditions that you are experiencing or have had in the past.

HEALTH HISTORY *CONTINUED*

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 Dependence
☐	☐ 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	☐	☐ Cancer
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	☐	☐ General Fatigue
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	☐	☐ Tumor
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	☐	☐ Muscular In-coordination
☐	☐ Arthritis	☐	☐ Hepatitis	☐	☐ Chronic Sinusitis
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder	☐	☐ Asthma
☐	☐ Visual Disturbances	☐	☐ Dizziness	☐	☐ Other:_____

For Females Only

☐ ☐ Birth Control Pills ☐ ☐ Hormonal Replacement ☐ ☐ Pregnancy ☐ Other: _____

Is there anything else pertinent to your visit today?

_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPPA)

I am aware of the County Health Department's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the Notice, and I request the following restrictions concerning the use of my personal medical information.

_____

_____

Signed: _____ Date: _____

*If not signed by the patient, please indicate your relationship to the patient (e.g., spouse, parent, etc.)
Relationship to Patient: _____
Witnessed by: _____

Internal Use Only: If a patient or patient's representative refused to sign the following Acknowledgement Receipt of Notice, please document the date and time the notice was presented to the patient and sign below.
Presented on:_____ By: _____ Title:_____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.
Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in lessening of the body's innate ability to express its maximum health potential.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other that vertebral subluxations. However, if during the course of chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____have read and fully understand the above statements.
(Print name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate/and adjust a minor child.

I, _____being the parent or legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission to receive chiropractic care.

_____ _____
(Signature) (Date)