

Patient Name _____ Date _____

Health History for Back 2 Back Chiropractic

Have you ever been diagnosed with the following: (Please circle)

AID/HIV	Gout	Pinched Nerve
Arthritis	Heart Disease	Polio
Bleeding Disorder	Hepatitis	Prostate Problem
Breast Lump	Herniated Disc	Rheumatoid Arthritis
Cancer	Kidney Disease	Stroke
Diabetes	Liver Disease	Thyroid Problems
Epilepsy	Migraines	Tuberculosis
Fractures (list)	Multiple Sclerosis	Tumors/Growths
_____	Mononucleosis	Other
_____	Osteoporosis	_____
_____	Pacemaker	_____

Please circle any problem you have had in the past 3 months

Musculo-skeletal

Lower Back Pain
Neck Pain
Arm Pain
Joint Pain
Stiffness
Walking Problems
Jaw Problems

Nervous System

Numbness
Paralysis
Dizziness
Confusion
Tingling in Leg/Arm
Stress

General

Headaches
Loss of Sleep
Fever (Date _____)

Gastrointestinal

Excessive Thirst
Frequent Nausea

Vomiting
Diarrhea
Constipation
Gall Bladder Trouble
Abdominal Cramps
Heartburn
Black Bloody Stools
Bowel Trouble

Urinary

Bladder Trouble
Painful Urination
Frequent Urination
Discolored Urine

Cardiovascular/ Respiratory

Chest Pain
Shortness of Breath
High Blood Pressure
Heart Problems
Varicose Veins
Ankle Swelling

Eyes, Ears, Nose & Throat

Vision Trouble
Dental Trouble
Earaches
Hearing Difficulty
Sore Throat

Females

Pregnancy
Date of Last Period?

Males

Sexual Problem
Prostrate Trouble

Medication (s)

Entrance Data Form for Back 2 Back Chiropractic

Name _____ Called Name _____
Address _____ City _____ State _____ Zip Code _____
Marital Status _____ Sex M / F Age _____ DOB _____ Email _____
Phone _____ Work Phone _____ Cell Phone _____
Primary Physician _____ Previous Chiropractor _____
How did you hear about our office? _____

Insurance (All information under insurance is that of the primary insured)

Primary Insured's Name _____ DOB _____ Employer _____
Are you expecting any changes to your insurance in the next 90 days? Yes or No If yes, explain

My primary or worst problem is _____ and first started _____
Did it begin (circle one) Gradually Suddenly Traumatically Why did this begin? _____
What makes your symptoms worse? _____ Better? _____
My Complaint is (circle any): dull sharp achy numbness tingling burning other _____
Does the pain or numbness travel to another area? (I.e. down arm or leg) _____
How often do you experience these symptoms? (Circle any) constantly intermittently occasionally frequently
If you have had this in the past, how long does it generally last? _____
Have you been to another doctor for this problem? Y / N Who? _____
Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (shoot me)
Additional Information:

My secondary or next problem is _____ and first started _____
Did it begin (circle one) Gradually Suddenly Traumatically Why did this begin? _____
What makes your symptoms worse? _____ Better? _____
My Complaint is (circle any): dull sharp achy numbness tingling burning other _____
Does the pain or numbness travel to another area? (I.e. down arm or leg) _____
How often do you experience these symptoms? (Circle any) constantly intermittently occasionally frequently
If you have had this in the past, how long does it generally last? _____
Have you been to another doctor for this problem? Y / N Who? _____
Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (shoot me)
Additional Information:

Trauma History: List any Accidents, Falls, Injuries, and Surgeries:

- 1 _____
- 2 _____
- 3 _____