o 124 Regency Park Dr. Suite 7, O'Fallon, IL 62269 Ph: (618) 622-3322

BACKFIT HEALTH SPINE

Name_____ Nickname_____ How did you hear about us_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone _____ SSN_____

Home Email_____ Date of Birth_____ Age_____ Gender ❑ Male ❑ Female ❑ Unspecified

Emergency Contact_____ Contact Phone #_____

Marital Status ❑ Single ❑ Married ❑ Other Children ❑ Yes ❑ No How Many?_____

Employment Status ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____ Employer_____ Employer Phone _____

Do you have insurance? ❑ Yes ❑ No Insurance Name_____

Primary insured?❑ Yes ❑ No If no, primary insured name and relationship to self_____ Their DOB_____

Family Physician_____ Phone _____

Current medications, COMPLETE FULLY:

RX Medication/Over The Counter	Dosage
1)	
2)	
3)	
4)	
5)	

Known Medical Conditions:

1) _____
2) _____
3) _____
4) _____
5) _____

List any known allergies you have had to any medications, foods or environment:

1) _____ 3) _____

2) _____ 4) _____

Do you suffer from seasonal allergies? ❑ Yes ❑ No If Yes, have you had allergy testing before? ❑ Yes ❑ No
Do you suffer from food sensitivity? ❑ Yes ❑ No If Yes, have you had food sensitivity testing before? ❑ Yes ❑ No

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. **(P) for Patient or (F) for family

❑ Alcoholism	(P or F)	❑ High Blood Pressure	(P or F)	❑ Stroke	(P or F)
❑ Anemia	(P or F)	❑ Kidney Disease	(P or F)	❑ Suicide Attempt	(P or F)
❑ Asthma	(P or F)	❑ Liver Disease	(P or F)	❑ Thyroid Disease	(P or F)
❑ Cancer/Tumor	(P or F)	❑ Hepatitis	(P or F)	❑ Heart Disease	(P or F)
❑ Diabetes	(P or F)	❑ Lung Disease	(P or F)	❑ Ulcers	(P or F)
❑ Drug Abuse	(P or F)	❑ Rheumatic Arthritis	(P or F)	❑ HIV or Other Immune Disease	(P or F)
❑ Depression	(P or F)	❑ Osteoarthritis	(P or F)	❑ High Cholesterol	(P or F)
❑ Epilepsy/Seizures	(P or F)	❑ Osteoporosis	(P or F)	❑ Other _____	

Past Health History: Please mark any condition you have now or had in the past

General
- ❑ Weight Loss
- ❑ Fatigue
- ❑ Fever

MSK
- ❑ Joint Pain
- ❑ Stiffness
- ❑ Muscle Pain
- ❑ Swollen Joints

Psychiatric
- ❑ Anxiety
- ❑ Depression

GU
- ❑ Erectile Dysfunction
- ❑ Leaky Bladder
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Painful urination

ENT
- ❑ Difficult Hearing
- ❑ Ear Ringing
- ❑ Vertigo
- ❑ Sinus Trouble
- ❑ Chronic Sore Throat

Hematology
- ❑ Easy Bruising
- ❑ Easy Bleeding

Endocrine
- ❑ Hair Loss
- ❑ Weight Gain

Respiratory
- ❑ Coughing
- ❑ Asthma
- ❑ Difficult Breathing

Cardiovascular
- ❑ Heart Murmur
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Short of Breath
- ❑ Fainting
- ❑ Swollen Ankles

Females Only
- ❑ Abnormal Mammo
- ❑ Abnormal Pap

Pregnant ❑ Y ❑ N
If so, how far along?_____

GI
- ❑ Heartburn
- ❑ Nausea
- ❑ Constipation
- ❑ Diarrhea
- ❑ Abdominal Pain

Eyes
- ❑ Glasses
- ❑ Eye Pain
- ❑ Double Vision

Skin
- ❑ Rash
- ❑ Itching
- ❑ Lesions

Neurological
- ❑ Strength Loss
- ❑ Numbness
- ❑ Tremors
- ❑ Memory Loss
- ❑ Headaches

Frequency_____

Patient Signature_____ Date_____ Dr Initials_____

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BACKFIT HEALTH SPINE

RV 12.2019

1st Chief Complaint: _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start?_____ Gradual / Sudden
Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint:_____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

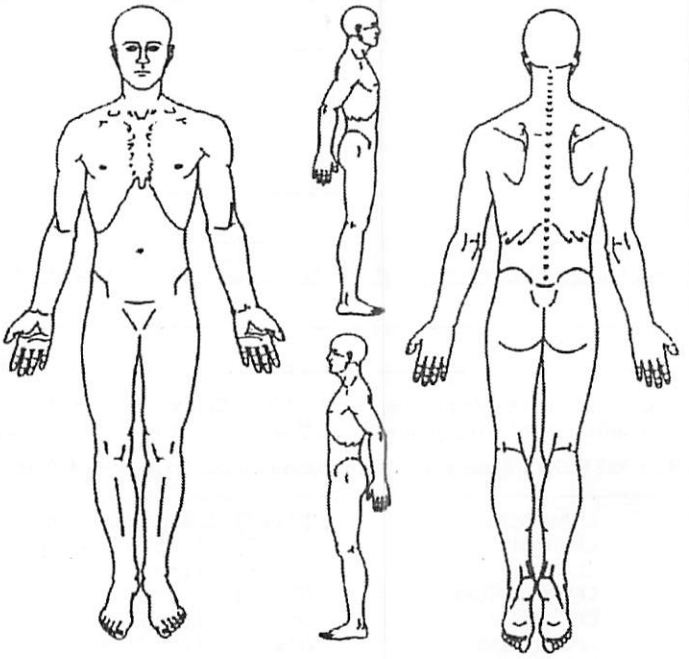
When did it start?_____ Gradual / Sudden
Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start?_____ Gradual / Sudden
Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show where you are experiencing all of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Have you ever had tests for your present condition? ❑ MRI ❑ X-ray ❑ CT ❑ Other_____

Do you have a pacemaker? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No If Yes, what is frequency_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke?_____

When was your last Physical Examination?_____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Any Surgeries? ❑ Yes ❑No If yes, list:_____

_____

Patient Name (please print)_____

Patient Signature_____ Date_____ Dr. Initials_____

RV 12.2019

BACKFIT HEALTH + SPINE

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illness, or deformities, which would otherwise not come to the attention of the physician.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprains/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at BackFit Health + Spine have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I agree to settle any claim or dispute that I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved and final determination will be made with BackFit Health + Spine authorized delegates.

My consent to care will last for 12 months starting from the date of my initial exam/visit to BackFit Health + Spine.

_____ _____

Patient Signature **Date**

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____ Date of last menstrual period _____

- € There is a possibility that I may be pregnant at this time
- € Yes, I am definitely pregnant
- € No, I am definitely not pregnant at this time

Patient's Signature _____ Date _____

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