

# PATIENT INFORMATION FORM

PI	ACUPUNCTURE	CASH	WC	PT	CHIROPRACTIC
Referring Doctor _____			Treating Doctor _____		

First Name \_\_\_\_\_ M.I. \_\_\_\_ Last Name \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_ DL#/STATE \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Circle Best Contact Phone Number: Home Work Cell

Email \_\_\_\_\_ Employer \_\_\_\_\_

Referred By \_\_\_\_\_ Primary Doctor \_\_\_\_\_

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Primary Insurance Co. Name & ID \_\_\_\_\_

Secondary/ Other Insurance Co. \_\_\_\_\_

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I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

**If the insurance company pays me directly I will bring the payment for the treatments along with an explanation of benefit endorsed by my signature to this office promptly.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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**I hereby request and consent to physical therapy and/or chiropractic and/or acupuncture treatment** for me (or my legal charge) provided by the providers at Back To Wellness. I do not expect the provider to be able to anticipate and explain all known risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure, which, the provider determines is in my best interest. I understand that there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I may request another person of my choice to be present in the treatment room during treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# HISTORY FORM

1. **Chief Complaint:** \_\_\_\_\_

Complaint Began when and how? \_\_\_\_\_

Have you had this pain before? \_\_\_\_\_

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other \_\_\_\_\_

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? \_\_\_\_\_

Do you have any numbness or tingling in your body? Where? \_\_\_\_\_

How frequent is complaint present, how long does it last? \_\_\_\_\_

Is your complaint getting better, getting worse, or unchanged since it began? \_\_\_\_\_

Is there any daily activity you have difficulty with or can no longer do? \_\_\_\_\_

Grade Intensity/Severity **Today** 0 1 2 3 4 5 6 7 8 9 10                      **General** pain level 0 1 2 3 4 5 6 7 8 9 10

Does anything aggravate the complaint? \_\_\_\_\_

Does anything make the complaint better? \_\_\_\_\_

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:**

3. **Past Health History:**

A. **Previous illnesses you've had in your life:** \_\_\_\_\_

B. **Previous accidents or injuries:** \_\_\_\_\_

C. **Allergies** \_\_\_\_\_

D. **Medications:**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E. **Surgeries:** \_\_\_\_\_

4. **Family Health History:**

Associated health problems of relatives: \_\_\_\_\_

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

5. **Social and Occupational History:**

A. **Job physical demands:** \_\_\_\_\_

B. **Recreational activities:** \_\_\_\_\_

C. **Sleeping position:** \_\_\_\_\_

D. **Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):** \_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_

## Automobile Accident Questionnaire

Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ : \_\_\_\_\_ AM/PM

Lawyer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Your Car Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_ Med pay? \_\_\_\_\_

Other Vehicle Car Ins. \_\_\_\_\_ Policy # \_\_\_\_\_ Phone: \_\_\_\_\_

Your Vehicle:  Auto  Light Truck  Truck  Motorcycle  SUV  Bus

Other Vehicle:  Auto  Light Truck  Truck  4) Motorcycle  SUV  Bus

Were You:  The driver  The Passenger  Right Rear  Left Rear

Were you wearing your seat belt?  Yes  No

Did the airbags deploy?  Yes  No

Where was your vehicle hit?  Front  Rear  Lt. Side  Rt. Side

Please describe the accident:

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Please Circle the part of body that was injured:  Head  Neck  Shoulder  Arm  
 Elbow  Wrist  Hand  Upper Back  Lower Back  Knee  Ankle  Foot

Did your symptoms develop:  Immediately  A few hours later  Next Day  
 After a few days

Did you receive medical aid at the site of the accident?  Yes  No

Additional complaints:  Difficulty Sleeping  Anxiety  Memory  Fogginess

Where did you go after the accident?  Hospital  Emergency Room  Home  
 Work  To this office  Resumed activities

Name of Hospital: \_\_\_\_\_

What treatment did you receive? \_\_\_\_\_

What is the estimated cost of damage to the vehicle you were in? \_\_\_\_\_

Are your current injuries interfering with your job performance? Missed work?

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Are your current injuries interfering with your lifestyle?

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Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_