

# 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 \_\_\_\_\_