

BACK TO HEALTH WELLNESS CENTER, INC

PATIENT INFORMATION

Please help me provide you with a thorough evaluation by completing all the forms I have given you. All the information you make available will be absolutely confidential.

YOUR NAME		Today's Date	
Age	Birth Date	S.S.#	
Street	City	State	Zip
Home Phone	Cell Phone		
Email Address			
Marital Status <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> S		Number of Children	Ages
Emergency Contact:	Name	Phone#	
Who Are You Here To See? <input type="checkbox"/> Chiropractor (Dr. Kuskin) <input type="checkbox"/> Physical Therapist (Karen Philhower)			
How did you hear about us? Referred By: _____ <input type="checkbox"/> Yellow Pages <input type="checkbox"/> News Paper Ad <input type="checkbox"/> Sign <input type="checkbox"/> Internet <input type="checkbox"/> Insurance Plan/Book <input type="checkbox"/> Insurance Plan/Internet <input type="checkbox"/> Doctors Health Journal			
Name of Insurance company?		<input type="checkbox"/> N/A	
Describe your primary complaint. _____ _____ _____			
Who is your primary care physician? _____			
Is this your first experience with chiropractic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If no, when was your last adjustment _____			
How long have you had this condition? _____			
What kinds of treatments have you tried? _____			
Have you been diagnosed with a specific problem? _____			
Has condition been getting better, worse or the same since it began? _____			
Have you ever had similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____			
<u>Accidents or Injuries</u> (describe; state when occurred) _____ _____ _____			
General			
Occupation _____		Stress Factors <input type="checkbox"/> physical <input type="checkbox"/> psychological <input type="checkbox"/> chemical	
Do you follow a regular exercise program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Alcohol per day _____	Tobacco per day _____	# of Years _____	Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No		Type _____	Quantity _____
Current Conditions			
**Please put a check next to any conditions you have experienced within the last 3 months. CONTINUED ON BACKSIDE			
General		<input type="checkbox"/> no complaints <input type="checkbox"/> weakness <input type="checkbox"/> fatigued <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fainting <input type="checkbox"/> flushed face	

Head	<input type="checkbox"/> no complaints <input type="checkbox"/> Injuries <input type="checkbox"/> headaches <input type="checkbox"/> poor memory <input type="checkbox"/> dizziness <input type="checkbox"/> lumps/bumps		
Eyes	<input type="checkbox"/> no complaints <input type="checkbox"/> corrective lenses <input type="checkbox"/> color blindness <input type="checkbox"/> eye pain <input type="checkbox"/> cataracts <input type="checkbox"/> excessive tearing <input type="checkbox"/> eye dryness <i>Date of Last Exam</i> _____		
Nose	<input type="checkbox"/> no complaints <input type="checkbox"/> bleeding <input type="checkbox"/> loss of smell <input type="checkbox"/> nasal discharge <input type="checkbox"/> post nasal drip <input type="checkbox"/> sinus surgery		
Ears	<input type="checkbox"/> no complaints <input type="checkbox"/> discharges <input type="checkbox"/> pain <input type="checkbox"/> loss of hearing <input type="checkbox"/> ringing		
Mouth/Throat	<input type="checkbox"/> no complaints <input type="checkbox"/> bleeding gums <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> loss of taste <input type="checkbox"/> ulcers <input type="checkbox"/> sores <input type="checkbox"/> TMJ <input type="checkbox"/> bad breath <input type="checkbox"/> sore throat <input type="checkbox"/> hoarseness		
Skin and Hair	<input type="checkbox"/> no complaints <input type="checkbox"/> color changes <input type="checkbox"/> nail changes <input type="checkbox"/> hair changes <input type="checkbox"/> moles <input type="checkbox"/> rashes <input type="checkbox"/> sores <input type="checkbox"/> hives <input type="checkbox"/> ulcerations <input type="checkbox"/> bruise easily <input type="checkbox"/> recent cuts/bruises		
Muscles and Bones	<input type="checkbox"/> no complaints <input type="checkbox"/> stiff neck <input type="checkbox"/> pain in neck <input type="checkbox"/> upper back <input type="checkbox"/> lower back pain <input type="checkbox"/> sciatica <input type="checkbox"/> shoulder <input type="checkbox"/> elbow <input type="checkbox"/> hands <input type="checkbox"/> hips <input type="checkbox"/> knees <input type="checkbox"/> foot/ankle <input type="checkbox"/> muscular pains <input type="checkbox"/> muscle weakness		
Lung <i>Now or in the past</i>	<input type="checkbox"/> no complaints <input type="checkbox"/> asthma <input type="checkbox"/> trouble breathing <input type="checkbox"/> coughing with phlegm <input type="checkbox"/> dry cough <input type="checkbox"/> chest pain <input type="checkbox"/> tightness in chest <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath <i>Other</i> _____		
Heart <i>Now or in the past</i>	<input type="checkbox"/> no complaints <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> open heart surgery <input type="checkbox"/> aneurysm <input type="checkbox"/> palpitations <input type="checkbox"/> varicose veins <input type="checkbox"/> bleed easily <input type="checkbox"/> chest discomfort <input type="checkbox"/> ankle swelling		
Digestion System <i>Now or in the past</i>	<input type="checkbox"/> no complaints <input type="checkbox"/> vomiting <input type="checkbox"/> IBS <input type="checkbox"/> indigestion <input type="checkbox"/> distention of abdomen after eating <input type="checkbox"/> problems with fatty or oily foods <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea/loose stools <input type="checkbox"/> gas		
Psychological	<input type="checkbox"/> no complaints <input type="checkbox"/> loss of control/violence potential <input type="checkbox"/> depression <input type="checkbox"/> treated for emotional problems in the past <input type="checkbox"/> ever considered suicide or attempted suicide <input type="checkbox"/> easily susceptible to stress		
Females Only			
Do you use birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type? _____	How long? _____	
Painful or tender breasts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have breast implants? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Irregular <input type="checkbox"/> light <input type="checkbox"/> heavy menstrual flow? <input type="checkbox"/> No		Painful Menses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Premature Births <input type="checkbox"/> Miscarriages <input type="checkbox"/> Abortions? <input type="checkbox"/> No			
Age menstrual cycle started _____		Age menstrual cycle stopped _____	
Cancer	Have you ever been diagnosed with cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No (include skin cancer) When _____	Type and Location	Current Status
Please List Surgeries	_____		

Family Health			
Describe mother's health briefly _____			
Describe father's health briefly _____			
I declare that the information provided on this form is accurate and complete to the best of my recollection. I will inform the doctor if any other facts about my condition come to mind during the time I am in active care at this office.			
Signed _____		Date _____	
<input type="checkbox"/> Parent or <input type="checkbox"/> Guardian Witness _____			