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 ❑**M** ❑**D** ❑**W** ❑**S**	**Number of Children** **Ages**		
Emergency Contact:	**Name**	**Phone#**	

Who Are You Here To See? ❑Chiropractor (Dr. Kuskin) ❑Physical Therapist (Karen Philhower)

How did you hear about us? Referred By:_____________________________ ❑Yellow Pages ❑News Paper Ad ❑Sign ❑Internet ❑Insurance Plan/Book ❑Insurance Plan/Internet ❑Google

Name of Insurance company? ❑ N/A

Describe your primary complaint. ____
____
____

Who is your primary care physician? ____

Is this your first experience with chiropractic? ❑Yes ❑No ❑NA *If no, when was your last adjustment*_________________

How long have you had this condition?____

What kinds of treatments have you tried?____

Have you ever been diagnosed with a herniated disc? ❑Yes ❑No What level?_______Date of most recent MRI________

Has condition been getting better, worse or the same since it began?______________________________

Have you ever had similar condition in the past? ❑Yes ❑No How often? ______________________________

Accidents or Injuries *(describe; state when occurred)* ______________________________
____
____

General

Occupation ____ Stress Factors ❑physical ❑psychological ❑chemical

Do you follow a regular exercise program? ❑Yes ❑No

Alcohol per day	Tobacco per day	# of Years	Do you have diabetes? ❑Yes ❑No
_______________	_______________	___________	

Recreational Drugs ❑Yes ❑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	❑no complaints ❑weakness ❑fatigued ❑fever ❑chills ❑night sweats ❑fainting ❑flushed face

Head	❑no complaints ❑Injuries ❑headaches ❑poor memory ❑dizziness ❑lumps/bumps
Eyes	❑no complaints ❑corrective lenses ❑color blindness ❑eye pain ❑cataracts ❑excessive tearing ❑eye dryness *Date of Last Exam*_______________
Nose	❑no complaints ❑bleeding ❑loss of smell ❑nasal discharge ❑post nasal drip ❑sinus surgery
Ears	❑no complaints ❑discharges ❑pain ❑loss of hearing ❑ringing
Mouth/Throat	❑no complaints ❑bleeding gums ❑difficulty swallowing ❑loss of taste ❑ulcers ❑sores ❑TMJ ❑bad breath ❑sore throat ❑hoarsness
Skin and Hair	❑no complaints ❑color changes ❑nail changes ❑hair changes ❑moles ❑rashes ❑sores ❑ ❑hives ❑ulcerations ❑bruise easily ❑recent cuts/bruises
Muscles and Bones	❑no complaints ❑stiff neck ❑pain in neck ❑upper back ❑lower back pain ❑sciatica ❑shoulder ❑elbow ❑hands ❑hips ❑knees ❑foot/ankle ❑muscular pains ❑muscle weakness
Lung ***Now or in the past***	❑no complaints ❑asthma ❑trouble breathing ❑coughing with phlegm ❑dry cough ❑chest pain ❑tightness in chest ❑wheezing ❑shortness of breath *Other*_____________________________
Heart ***Now or in the past***	❑no complaints ❑high blood pressure ❑low blood pressure ❑open heart surgery ❑aneurysm ❑palpitations ❑varicose veins ❑bleed easily ❑chest discomfort ❑ankle swelling
Digestion System ***Now or in the past***	❑no complaints ❑vomiting ❑IBS ❑indigestion ❑distention of abdomen after eating ❑problems with fatty or oily foods ❑constipation ❑diarrhea/loose stools ❑gas
Psychological	❑no complaints ❑loss of control/violence potential ❑depression ❑treated for emotional problems in the past ❑ever considered suicide or attempted suicide ❑easily susceptible to stress

Females Only		
Do you use birth control? ❑Yes ❑No	What type?___________________________	How long?__________
Painful or tender breasts? ❑Yes ❑No	Do you have breast implants? ❑Yes ❑No	
❑Irregular ❑light ❑heavy menstrual flow? ❑No	Painful Menses? ❑Yes ❑No	
❑Premature Births ❑Miscarriages ❑Abortions? ❑No		
Age menstrual cycle started ______________	Age menstrual cycle stopped ______________	

Cancer	Have you ever been diagnosed with cancer? ❑Yes ❑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

❑Parent or ❑Guardian

Witness ______________________________________

Please List All Prescription Medications You Currently Take:

(continue on back if not enough room)

Name	Dosage	Frequency
Ex. Nexium	20mg Capsule	Once per day

Allergies to Medications:____

How would you rate your health on a scale of 1-10? (with 10 being the worst)

Overall Health______________ Chronic Pain_____________ Sleep_____________

Stress_____________________ Energy________________

Please Circle Answer

Marital Status: Divorced Married Separated Single Widow Widower

Race: American Indian/Alaskan Native Asian Black/African American

Native Hawaiian/Pacific Islands White Declined to Specify

Ethnicity: Hispanic/Latino Not Hispanic or Latino Do not wish to answer

Preferred Language: Chinese English French German Italian

Portuguese Russian Spanish

Do You Smoke: Everyday Some Days Not anymore Never smoked

If you smoke/smoked: How much to you smoke?________________________

What year did you start?____

What year did you quit?____

Preferred Method of Contact: Phone Email Text Postal Mail Fax Declined

If email what is your email address?____

If phone/text what is the best number?_______________________________________

BACK TO HEALTH WELLNESS CENTER

HISTORY OF INJURY FROM MOTOR VEHICLE CRASH

YOUR NAME ______________________ Date ______________ Injury Date ______________

☐Driver ☐Passenger (☐Front seat ☐Rear seat ☐R ☐L) Anyone else in your vehicle with you ☐Y ☐N

What area of your car was struck: ☐Rear ☐Front ☐Driver Side ☐Passenger Side

☐Front Right Oblique ☐Front Left Oblique ☐Rear Right Oblique ☐Rear Left Oblique

Road conditions at time of crash ☐Dry ☐Wet ☐Ice ☐Sandy

What was the size, make, model and year of the vehicle that struck your vehicle ______________________

____

What is the make, model and year of your vehicle ______________________

What approximate speed was the other vehicle traveling when it hit you

At time of **impact** was your vehicle moving (at what speed_____) ☐straight ☐turning ☐right ☐left

☐stopped - did you have your foot on the break ☐Y ☐N

Were your tires in the ☐straight ahead position or ☐turned to the ☐right or ☐left and to what degree__________

After the impact was your vehicle pushed ☐forward ☐backward ☐straight ☐spun to the ☐right ☐left

Did your car strike anything else______________________Did your vehicle need to be towed? ☐Y ☐N

Car equipped with ☐**shoulder/lap** belt harness ☐lap harness only ☐shoulder harness only

and was ☐on ☐off; ☐did or ☐failed to restrain you.

Car equipped with headrests that were positioned ☐correctly ☐incorrectly ______________________

Headrest was ☐inches above and away from the top of your head ______________________

☐inches below and away from the top of your head ______________________

Your **seat** ☐was ☐was not in the full upright position ☐Seat back broke upon impact

Angle of the back of your seat was more than 90 degrees or slanting back position ☐Y ☐N

☐ Vehicle equipped with airbag ☐Y ☐N

Air bag ☐ did ☐ didn't deploy causing injury to ______________________

Patient's **head** was ☐ Straight ahead ☐Up degrees __________ ☐ Down degrees ________

☐ Right degrees__________ ☐ Left degrees __________ ☐Combination __________

Your **body** was out of position (explain)______________________

You ☐did ☐did not **see accident coming** ☐did ☐did not have time to brace for impact

You ☐cannot remember ☐did not ☐did **strike body part** ☐head ☐face ☐shoulder (☐R ☐L) ☐knee (☐R ☐L) ☐chest ☐hip (☐R ☐L) ☐ankle (☐R ☐L) ☐foot (☐R ☐L) ☐wrist (☐R ☐L) ☐hand (☐R ☐L) ☐elbow (☐R ☐L)

With ☐steering wheel ☐door ☐dashboard ☐windshield ☐airbag ☐rearview mirror ☐other

You ☐did ☐did not lose **consciousness**______________________

You ☐were ☐were not **cut or bleeding** ______________________

☐did ☐did not have **broken bones** ______________________

Scale 1 to 10 — 10 being the worst pain ever felt

PRIOR TO THIS INJURY

Previous automobile crashes ❑Y ❑N ❑See Attachment
Any other accidents in the past ❑Y ❑N ____
Have you ever had cancer? ❑Y ❑N ____
Does your pain ever wake from a sound sleep? ❑Y ❑N
Are you losing weight now without trying? ❑Y ❑N
Are you coughing up blood or noticing it in your stools or urine? ❑Y ❑N
Have you had any loss of bladder or bowel control? ❑Y ❑N
Have you lost consciousness recently? ❑Y ❑N ____
Concerning your vision, have you had double vision or problems with seeing recently? ❑Y ❑N
Are you having any problem with swallowing? ❑Y ❑N
Are you seeing any other doctor now for any reason? ❑Y ❑N ____
Do you have any other symptoms or health problems? ❑Y ❑N ____
Are you taking any medications or over-the-counter drugs now? ❑Y ❑N ____
Have you been sick or had an infection lately? ❑Y ❑N ____
Is there any chance that you are pregnant now? ❑Y ❑N
Have you recently been injured prior to this injury? ❑Y ❑N ____
Sleep ❑restful ❑restless ❑6-8 hrs ❑8-10 hrs ____
Job description ____

School activities ____

Daily living ____

Drug use: smoker ____ alcohol ____
pain killers ____ muscle relaxants
other ____
Hobbies ____

PRESENT TIME

❑N/A Anyone else in your car injured ❑Y ❑N ____

When did your symptoms first appear ____
Has your symptoms changed since the time of the accident until now *(are the symptoms in a different location, intensity or frequency)* ____

Did you go to the hospital ❑Y ❑N How did you get there ____
How long was the hospital stay ____
What was done at the hospital ____
What were the results ____
How did you leave the hospital ____
Who drove ____
Has there been any visual disturbances ❑Y ❑N ____
Ringing in the ears ❑Y ❑N
Memory loss ❑Y ❑N ____
Emotional changes ❑Y ❑N ____

At the time of the present accident did you feel:
❑Y ❑N Dazed ❑Y ❑N Disoriented ❑Y ❑N Confused

Post-Concussion Syndrome-Symptoms

1. ❑Y ❑N Light Headedness
2. ❑Y ❑N Vertigo/dizziness
3. ❑Y ❑N Neck Pain
4. ❑Y ❑N Headache
5. ❑Y ❑N Photophobia (affected by light)
6. ❑Y ❑N Phonophobia (affected by sounds)
7. ❑Y ❑N Tinnitis (ringing in the ears)
8. ❑Y ❑N Impaired memory
9. ❑Y ❑N Easy distractibility
10. ❑Y ❑N Impaired comprehension
11. ❑Y ❑N Forgetfulness
12. ❑Y ❑N Impaired logical thought
13. ❑Y ❑N Difficulty with new or abstracted concepts
14. ❑Y ❑N Insomnia (difficulty in sleeping)
15. ❑Y ❑N Easy fatigability
16. ❑Y ❑N Apathy
17. ❑Y ❑N Outbursts of anger
18. ❑Y ❑N Mood swings
19. ❑Y ❑N Depression
20. ❑Y ❑N Loss of libido
21. ❑Y ❑N Personality change

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BACK TO HEALTH WELLNESS CENTER DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by Dr. Robert Kuskin and/or other licensed Doctors of Chiropractic working at Back to Health Wellness Center, Inc.. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had or will have the opportunity to discuss with the Dr. Kuskin, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.
I understand, and I am informed that, there are some risks to chiropractic examination and treatment including, but not limited to:

- Increased symptoms and pain
- spinal or disc injuries
- dislocations
- sprains/strains
- fractures (broken bones)
- no improvement of symptoms or pain
- stroke

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had or will have an opportunity to ask questions. All of my questions have or will have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

To be completed by the patient:

____
print name

____
signature of patient

____
date signed

To be completed by the patient's representative:

____
print name of patient

____
print name of patient's representative

____
signature of patient's representative

as:______________________
relationship/authority of patient's representative

____
date signed

To be completed by doctor or staff:

____
witness to patient's signature

____
date

____
translated by

____
date

BACK TO HEALTH WELLNESS CENTER
OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1) **If you do not have insurance:** All payments are expected at the time of service or on an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. We provide multiple payment options to make care an affordable part of your family budget. If you have a problem with payment please let us know, we will work with you.

2) **If you have insurance:** All deductibles and co-payments are expected at the time of service or on an authorized payment plan. Your co-insurance balance may not exceed $100 at any time or care may be terminated. We provide multiple payment options to make care an affordable part of your family budget. If you have a problem with payment please let us know, we will work with you.

   You are considered a cash patient until your insurance is verified and we get our first explanation of benefits from your insurance company. We will accept assignment for most secondary insurance carriers.

   Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each insurance carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become due and payable in full by you, regardless of any claim submitted.

Patient's printed name:_______________________________

Signature:_______________________________________ Date:__________

For your convenience you may retain your credit card number on file with us. (Optional)

Card#:________________________________Expiration date:___________

Name as it appears on the card:______________________________________

BACK TO HEALTH WELLNESS CENTER

OPEN ENVIRONMENT NOTIFICATION

This office has patients treated in an "open environment" – not behind closed doors (except for chiropractic and massage). Please check here to indicate that you understand and accept this policy. If privacy is an issue, you may discuss this with your treating professional.

☐ **Yes. I understand and accept this policy.**

Patient Signature:________________________________ Date:________________

Print Name:_____________________________________

PATIENT PRIVACY

This form states that Back To Health Wellness Center has a patient privacy policy and the patient has been informed that he/she may obtain the complete patient privacy policy at any time.

Patient Signature:______________________________ Date:________________

Print Name:___________________________________

BACK TO HEALTH WELLNESS CENTER
HIPPA/OSHA POLICY ON ELECTRODES

Please be aware that you may incur a one time $9.00 charge if electrodes are used during therapeutic modalities as prescribed by your healthcare provider. We will house the electrodes for you in the office, but they are yours.

This is not covered by any health insurance program. Please be aware that Back To Health Wellness Center is giving these electrodes to you at cost. We wish to provide you with the best, most sanitary care while conforming to all HIPPA and OSHA requirements.

Sincerely,

Robert I. Kuskin, D .C.
Karen Philhower, P.T.

Please Initial:________