Back In Action Spine and Health Centers

Date:_____

Last Name First Name Middle Name

Address

Marital Status:
Single Married Divorced Widowed

City State/Province

Spouse's Name

Spouse's Phone Number

Male Female

Social Security Number Date of Birth (MM/DD/YYYY)

Email Address Cell Phone Number

Childs Name and Age

Emergency Contact Phone Number

Childs Name and Age

Your Occupation

Childs Name and Age

Employer

May we contact you at work?
Yes No

Address

What hours do you work?
First Second Third Varies

City State/Province Zip Code Work Phone

Insurance Carrier Policy Number Primary Care Provider

Insured's Last Name First Name Middle Initial

Who carries this policy? Self Spouse Parent

Insured's Employer Address

City State/Province Zip Code Employers Phone

Who may we thank for referring you? □ TV □ Facebook □ Radio □ Person _____

1. The symptom(s) that have prompted me to seek care today include: _____

_____

Please list any other symptom(s) not listed above: _____

2. Are they a result of (please mark)

□ Accident/Injury □ Auto □ Work □ Other _____

□ Worsening long term problem □ An interest in: □ Wellness □ Other _____

3. Onset (when did you first notice your current symptoms?) _____

4. Intensity (how extreme are your current symptoms?) 0 1 2 3 4 5 6 7 8 9 10

5. Duration and Timing (When did it start & how often do you feel it?)

□ Constant □ Comes and goes (how often?) _____

6. Quality of Symptoms (what does it feel like?)

□ Numbness □ Nagging

□ Tingling □ Sharp

□ Stiffness □ Burning

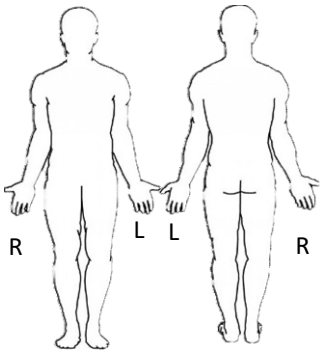
□ Dull □ Shooting

□ Aching □ Throbbing

□ Cramps □ Stabbing

□ Other: _____

7. Location: (where does it hurt?)



Circle the area(s) on the illustration

8. Radiation (does it affect other areas of your body?)

To what area(s) does the pain radiate or shoot?

_____

_____

9.Aggravation or relieving factors (what makes it better or worse, such as time of day, movements, activities, etc..)

Worsen _____

Relieve _____

10. Prior interventions (what have you done to relieve symptoms)

□ Prescription Medications □ Supplements

□ Over the counter drugs □ Acupuncture

□ Homeopathic remedies □ Chiropractic

□ Massage

□ Other: _____

11. What else should Dr. McKelroy know about your condition? _____

_____

12. How does your current condition interfere with your:

Work/Career: _____

Recreation activities: _____

Household responsibilities: _____

Personal relationship: _____

13. Review of Systems: Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please mark the box beside any condition that you've HAD or currently HAVE & initial to the right

Had	Have		Had	Have		Had	Have		Initial
□	□	Osteoporosis	□	□	Arthritis	□	□	Apnea	
□	□	Knee injury	□	□	Foot/Ankle Pain	□	□	Ulcer	
□	□	Anxiety	□	□	Depression	□	□	Ringing in ears	

Had	Have		Had	Have		Had	Have		Initial
☐	☐	High Blood Pressure	☐	☐	Low Blood Pressure	☐	☐	Psoriasis	
☐	☐	Neck Pain	☐	☐	Emphysema	☐	☐	Back Pain	
☐	☐	Elbow/Wrist pain	☐	☐	Food Sensitivities	☐	☐	TMJ Problems	
☐	☐	Headache	☐	☐	Hearing loss	☐	☐	Dizziness	
☐	☐	High Cholesterol	☐	☐	Eczema	☐	☐	Poor Circulation	
☐	☐	Hay Fever	☐	☐	Scoliosis	☐	☐	Shortness of breath	
☐	☐	Heartburn	☐	☐	Shoulder Pain	☐	☐	Constipation	
☐	☐	Chronic ear infections	☐	☐	Pins and Needles	☐	☐	Loss of smell	
☐	☐	Acne	☐	☐	Angina	☐	☐	Hair Loss	
☐	☐	Hip Disorder	☐	☐	Pneumonia	☐	☐	Thyroid Issues	
☐	☐	Poor Posture	☐	☐	Diarrhea	☐	☐	Kidney Stones	
☐	☐	Numbness	☐	☐	Loss of taste	☐	☐	Fainting	
☐	☐	Excessive bruising	☐	☐	Rash	☐	☐	Immune Disorders	
☐	☐	Infertility	☐	☐	Poor Appetite	☐	☐	Swollen Glands	
☐	☐	Low Libido	☐	☐	Frequent infection	☐	☐	Erectile Dysfunction	
☐	☐	Hypoglycemia	☐	☐	Prostate Issues	☐	☐	Sudden weight change	
☐	☐	Bedwetting	☐	☐	Fatigue	☐	☐	Low energy	
☐	☐	PMS Symptoms							
☐	☐	Weakness							

Patient Name

Past Personal, Family, and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments.

Please complete each section fully.

14. Illness

Check the illnesses you have HAD in the past or HAVE now

Had	Have		Had	Have	
☐	☐	Aids	☐	☐	Rheumatic Fever
☐	☐	Alcoholism	☐	☐	Scarlet Fever
☐	☐	Allergies	☐	☐	Sexually Transmitted Diseases
☐	☐	Arteriosclerosis	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Typhoid Fever
☐	☐	Chicken Pox	☐	☐	Ulcer
☐	☐	Diabetes	☐	☐	Other
☐	☐	Eczema	☐	☐	_____
☐	☐	Emphysema	☐	☐	_____
☐	☐	Epilepsy	☐	☐	_____
☐	☐	Glaucoma	☐	☐	_____
☐	☐	Goiter			
☐	☐	Gout			
☐	☐	Heart Disease			
☐	☐	Hepatitis			
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			

15. Operations: (Surgical interventions which may or may not have included hospitalization)

Had	Have	
☐	☐	Appendix Removal
☐	☐	Bypass Surgery
☐	☐	Cancer
☐	☐	Cosmetic Surgery
☐	☐	Elective Surgery
☐	☐	Eye Surgery
☐	☐	Hysterectomy
☐	☐	Pacemaker
☐	☐	Tonsillectomy
☐	☐	Vasectomy
☐	☐	Other
☐	☐	_____
☐	☐	_____
☐	☐	_____

16. Injuries (have you ever)

☐	☐	Fractured or broken a bone
☐	☐	Hade a spine or nerve disorder
☐	☐	been knocked unconscious
☐	☐	been involved in an accident

Consultation Notes

☐ ☐ Pneumonia ☐ ☐ use(d) a brace for support

☐ ☐ Polio

Doctor's Initials _____

17. Family History (Check all that apply)

Relative	Living/ Diseased	Stroke	Heart Disease	Cancer	Rheumatoid Arthritis	Diabetes	Multiple Sclerosis	Lung Disease	Bone Disease
Mother	L / D								
Father	L / D								
Sibling	L / D								
Sibling	L / D								
Sibling	L / D								
Sibling	L / D								

18. Are there any other health issues that you know about? _____

_____

19. Social History

Health Habits and Stress Levels

					Yes	No	
Alcohol Use	☐ Daily	☐ Weekly	How much?	_____	☐	☐	Prayer or Meditation
Coffee Use	☐ Daily	☐ Weekly	How much?	_____	☐	☐	Job Pressure/Stress
Tobacco Use	☐ Daily	☐ Weekly	How much?	_____	☐	☐	Financial Peace?
Exercising	☐ Daily	☐ Weekly	How much?	_____	☐	☐	Vaccinated?
Pain Relievers	☐ Daily	☐ Weekly	How much?	_____	☐	☐	Mercury filings?
Soft Drinks	☐ Daily	☐ Weekly	How much?	_____	☐	☐	Recreational Drugs
Water Intake	☐ Daily	☐ Weekly	How much?	_____			

20. Activities of Daily Living:

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting	☐	☐	☐	☐
Rising out of a chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending Over	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting out of a car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐
Grocery Shopping	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Lifting Objects	☐	☐	☐	☐
Reaching Overhead	☐	☐	☐	☐
Showering/Bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐

21. What is the major stressor in your life?

_____

22. How much sleep do you get per night?

_____ hours

23. What is the type & approximate age of your mattress and pillow?_____

24. What is your preferred sleeping position?

_____

25. Describe your typical eating habits.

☐ Skip Breakfast ☐ Three meals a day

☐ Two meals a day ☐ Snacking between meals

26. What is the most significant thing you could do to improve your health?

_____

_____

27.What else have you done to treat this pain?

_____

_____

_____

Exercising	☐	☐	☐	☐
Yard Work	☐	☐	☐	☐

28. In addition to the main reason for your visit today, what additional health goals do you have?

_____

29. Medical Doctor's name: _____ Phone number: _____

Other problems: _____

What other pain do you have? _____

What caused this pain? _____

When did this pain start? _____

How bad is this pain? (circle one that applies): Mild, Moderate, Severe, Intolerable

Circle the word/words that best describes the pain:

Cramping, Aching, Dull, Sharp, Shooting, Deep, Throb, Nagging, Burning, Stinging, Pressure

Does this pain travel to any other area, if so where: _____

What makes the pain better? _____

What makes the pain worse? _____

What else have you done to treat this pain? _____

Acknowledgements

To set clear expectations, improve communications & help you get the best results in the shorter amount of time, please read each statement & initial

Initial _____ I instruct the chiropractor to deliver the care that in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing from medicine and does not proclaim to cure any named disease or entity.

Initial _____ I have received a copy of the Privacy Policy and understands that it describes how my personal health information is and released on my behalf for seeking reimbursement form any involved third parties

Initial _____ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period. (MM/DD/YYYY) _____

Initial _____ I grant permission to be called to confirm or reschedule an appointment & to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initial _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive

Initial _____ To the best of my ability the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print the child's full name: _____

Signature _____ Date (MM/DD/YYYY) _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and meth that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment! An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes laceration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. Howeve if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advi you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the service of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) (Date)

X-RAY RELEASE

- Male Release: This is to certify that I gave my permission to this office to preform an x-ray evaluation.
- Female Pregnancy Release: This it to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to preform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:_____(MM/DD/YY

_____ _____
(Signature) (Date)

(Signature) (Date)

ACKNOWLEDGEMENT OF RECEIPT NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Back In Action's "NOTICE OF PRIVACY PRACTICES".

As required by the Privacy Regulations, Back In Action has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required y the Privacy Regulations, I am aware that Back In Action has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

□ I wish to file a "Request for Restriction" of my Protected Health Information

□ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

□ I wish to object to the following in the "Notice of Privacy Practices."

_____

_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____

Signature Date

_____

Print Name

_____

(Office Use ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

_____

_____