Back In Action Health Resource Center
NEW PATIENT FORM

Name: (F) _____ (M) _____ (L) _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Primary Phone Number: _____ ☐ home ☐ cell ☐ work

Secondary Phone Number: _____ ☐ home ☐ cell ☐ work

Date of Birth: _____ SS#: - - _____ Marital status: _____

Employer: _____ Occupation: _____

Primary Care Physician: _____ Insurance Carrier: _____

Date of last physical exam and any results of concern: _____

How did you hear about our office? _____

Do you know today's winning lottery number? ☐ Yes ☐ N *(please print clearly)* _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Poor

Why are you here and what do you hope to gain from your experience?

_____

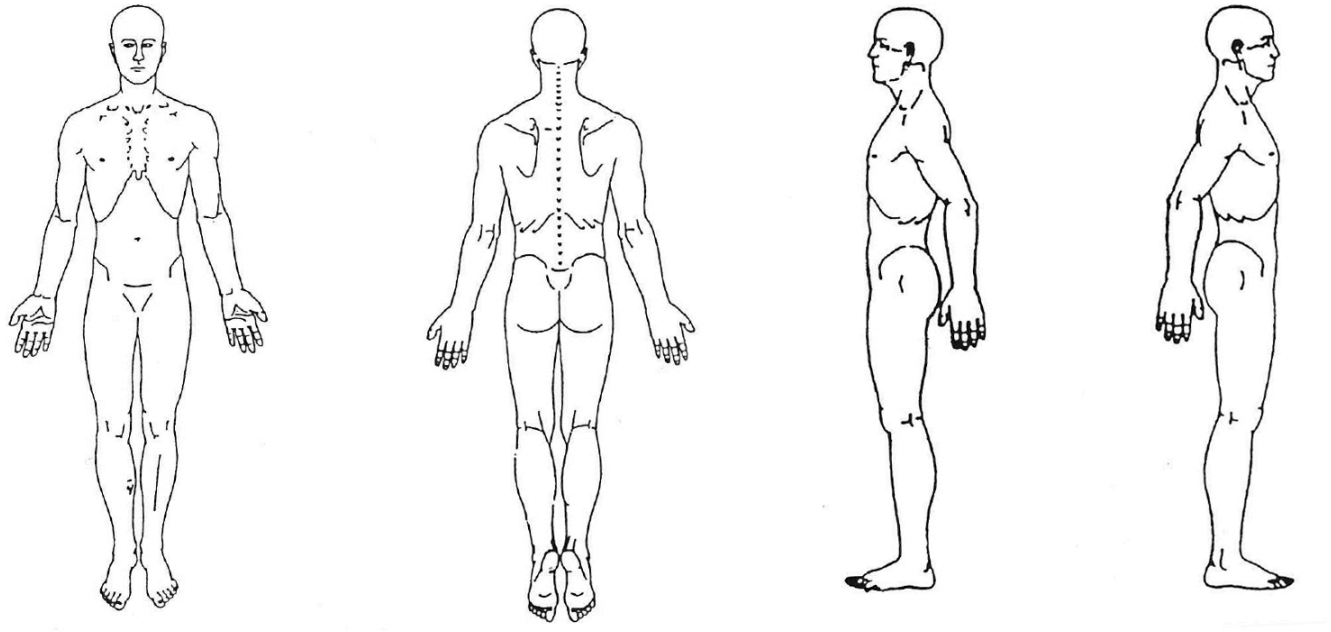
_____

_____

Please draw on the diagram below, indicating any areas of pain or problems, using the following letters to indicate specific descriptions:

A=Ache B=Burning N=Numbness/Tingling S=Sharp/Stabbing T=Tight W=Weakness O=Other

Next to all problem areas, also indicate your level of pain on a 1-10 scale: 0=none/10=unbearable



Do you have pain/problems in any of the following regions?

☐ face ☐ jaw ☐ neck ☐ back ☐ shoulder ☐ elbow
☐ wrist ☐ hand ☐ hip ☐ ankle ☐ foot

Do you have any of the following?

☐ headaches ☐ pms ☐ cancer ☐ diabetes ☐ arthritis
☐ allergies ☐ tendonitis ☐ hearing aid ☐ ringing in ears ☐ contact lenses
☐ osteoporosis ☐ sleep problems ☐ skin sensitivity ☐ digestive issues ☐ urinary issues
☐ menstrual issues ☐ constipation ☐ diarrhea ☐ artificial arms or legs
☐ high blood pressure ☐ high cholesterol ☐ sense of humor

Any family history of: ☐ Cancer ☐ Heart Disease ☐ Arthritis ☐ Osteoporosis ☐ Stroke

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Any past surgeries of note? _____

Any past auto injuries? _____

Any other relevant injuries? _____

How old is your mattress? _____ How many pillows do you use? _____

Do you sleep on your: ☐ side ☐ back ☐ stomach

What is your current exercise program? _____

Do you smoke? ☐ No ☐ Yes How often? _____

Drink alcohol? ☐ No ☐ Yes How often? _____

Drink caffeine? ☐ No ☐ Yes How often? _____

Please list all prescription and over the counter meds you currently take:

_____

Please list all vitamins and supplements you currently take:

_____

Do you have prior experience with: ☐ Chiropractic ☐ Massage ☐ Acupuncture

Have you received any previous treatment for your issue(s): ☐ Yes ☐ No
If yes, please explain: _____

What is your motivation level on a scale of 1-10 (0=none, 10=extremely) in receiving nutritional or home exercise info relative to your condition? _____

Is there anything else not contained in this form that needs to be discussed?

_____

_____

_____

Signature: _____ Date: _____