Back to Back Chiropractic Inc.
New Patient Health History Form

Date: _____

1 PATIENT INFORMATION

Name: _____
Address: _____
City: _____ Postal Code: ____
Care Card #: _____
DOB:(M/D/Y)___/___/___ Age:____
Occupation: _____
Sex: _____
○ Single ○ Married ○ Separated ○ Widowed
Spouse's Name: _____
Do you have children? If so, how many? _____
What are you seeking? _____

◯ I have a disease, injury or symptom and I am only interested in help with this specific problem.
◯ I have a disease, injury or symptom and I am interested in help with this specific problem, and learning how to prevent it from re-occuring in the future.

2 CONTACT INFORMATION

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

EMERGENCY CONTACT
Name: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

*For reminder notices the best way to contact me is:
☐ **Text Message** **or** **Email** ☐
Cell phone provider: _____

3 ACCIDENT INFORMATION

Is this complaint related to an accident?
◯ Work ◯ Automobile
If yes, report to front desk for additional forms.
To whom have you reported the accident?
◯ ICBC ◯ WCB ◯ Employer ◯ Other _____

4 REFERRAL INFORMATION

How did you hear about our office?
◯ Friend/Family Member
◯ Sign
◯ Other: _____

If referred, whom may we thank for referring you to our clinic?
_____

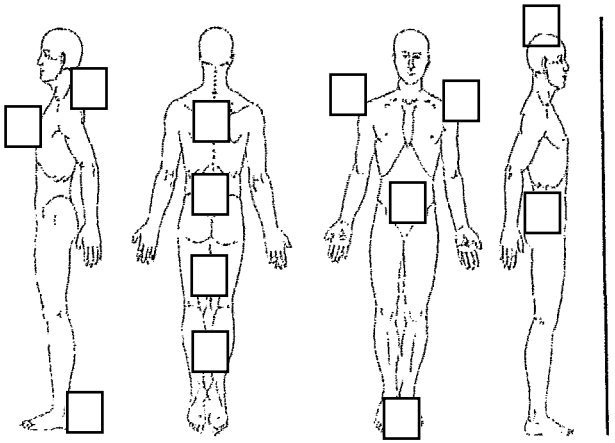
5 CURRENT PATIENT CONDITION

Describe your main symptom(s)/problem(s) and area of injury or pain? _____
When and how did your symptoms begin: _____
Have you had this before? Explain: _____
Is your condition getting progressively: ◯ Worse ◯ Better ◯ Staying Same
Is this symptom: ◯ Constant ◯ Comes and goes
My symptoms are worse in the: ◯ Morning ◯ Daytime ◉ Evening Please mark where it hurts

How does it feel? ☐ Burning ☐ Sharp ☐ Stiff ☐ Ache
☐ Numbness ☐ Shooting ☐ Tingling ☐ Other _____

What makes your symptom(s) worse? _____
_____
_____

What makes your symptom(s) better? _____
_____
_____



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HEALTH HISTORY

What other treatments have you had for this condition? _____
Have you recently had any X-rays taken or other special imaging such as MRI or CT Scan? _____
If yes, what type—body part/reason for imaging: _____
Are you currently receiving health care for any other reason? _____
If yes, where and from whom? If available, please provide contact information. _____
When was the last time you received a physical exam: _____
Have you ever had any cosmetic procedures done, if so, please specify. _____

Which medications, either by prescription or over-the-counter, are you currently taking or have you taken in the past 6 months?

☐ Antibiotics ☐ Antideppressants ☐ Sleep medication ☐ H2 Blockers/Ulcer medication
☐ Thyroid medication ☐ Cortisone/Prednisone ☐ Pain relievers ☐ Cholesteral-lowering medication
☐ Laxatives ☐ Muscle relaxant ☐ Antacids ☐ Blood pressure medication

Other: _____
Please list name (if available) and dosage: _____
What vitamins, herbs, or minerals do you currently take? *Please list dosage*: _____

Please check any symptoms or conditions that apply to you:

☐ Angina/chest pain	☐ Difficulty breathing	☐ Numbness/tingling	☐ Fatigue	☐ Frequent urination
☐ Heart disease	☐ Shortness of breath	☐ Shakiness in hands	☐ Neck pain/stiffness	☐ Urinary infections
☐ High blood pressure	☐ Asthma	☐ Headaches	☐ Loss of smell	☐ Incontinence
☐ Irregular heart rhythm	☐ Bronchitis	☐ Jaw pain	☐ Loss of taste	☐ Joint pain/ stiffness
☐ Light headed/fainting	☐ Anxiety/nervousness	☐ Concussions	☐ Nosebleeds	☐ Arthritis
☐ Easy bleeding/bruising	☐ Depression	☐ Recurrent infections	☐ Vision impairment/change	☐ Sleep problems
☐ Varicose veins	☐ Poor concentration	☐ Hair loss	☐ Abdominal pain/cramps	☐ Other: _____
☐ Anemia	☐ Memory loss	☐ Brittle nails	☐ Constipation	
☐ Cold hands/feet	☐ Vertigo/dizziness	☐ Excess thirst	☐ Diarrhea	
☐ Swelling in feet/ankles	☐ Seizures	☐ Excess hunger	☐ Black/bloody stools	
	☐ Muscle weakness	☐ Heat/cold intolerance	☐ Pain with urination	

Family History: Family member present or past health conditions (i.e. heart disease, Alzheimer's, stroke, high blood pressure, diabetes, mental illness, cancer, arthritis, etc.)

Member of Family	**Condition**
_____	_____
_____	_____
_____	_____
_____	_____

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Check the appropriate bubbles...

	Yes	No		Yes	No
Get 6-8 hours of sleep nightly?	☐	☐	Wake-up refreshed?	☐	☐
In a supportive relationship?	☐	☐	Enjoy your work?	☐	☐
Take vacations?	☐	☐	Spend time outside?	☐	☐
Eat out more than 3 times/week?	☐	☐	Eat 3-6 meals daily?	☐	☐
History of abuse?	☐	☐	Go on a diet more than twice/yr?	☐	☐
Major life trauma in past 3 years?	☐	☐	Watch TV? Hours/day? _____	☐	☐
Drink alcohol? Drinks/day? _____	☐	☐	Read? Hours/day? _____	☐	☐
Use tobacco? Packs/day? _____	☐	☐	Drink coffee?	☐	☐
How many years? _____	☐	☐	Drink tea?	☐	☐
Use recreational drugs?	☐	☐	Drink soda/cola?	☐	☐
Treated for substance abuse?	☐	☐	Add sugar/salt to food?	☐	☐