Title:

o Mr. o Mrs. o Miss o Dr.

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____) _____

Cell Phone: (_____)_____

Date of Birth: _____

Primary Physicians Name: _____ Phone Number: _____

Address: _____

Employment Status:

- o Employed
- o Full time Student
- o Part time student
- o Other

Spouse First Name: _____ **Middle initial:** _____ **Last Name**: _____

Spouse's date of birth: _____

Emergency Contact Name: _____ Phone Number: _____

Insurance

Subscriber's name: _____ **Date of Birth:**_____

Relationship to patient: _____ **Insurance Company:** _____

Group #:_____

Is the patient covered by additional insurance?

- o Yes
- o No

Subscribers Name: _____ Date of Birth: _____

Relationship to patient: _____

Insurance Company: _____

Assignment & Release

I, _____ the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign Back In Motion Chiropractic WNY all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on insurance submissions.

Responsible Party:_____Date: _____

Is it okay to call you at work?

- o Yes
- o No

How Did you hear about our clinic?

- o Family member (Name of Family member:_____)
- o Friend
- o Physician
- o Employer
- o Attorney
- o Internet
- o Other

Health History /Medical Conditions: Have you had any of the following

- o Alcoholism
- o Anemia
- o Anorexia/bullemia
- o Arthritis
- o Asthma
- o Back/neck condition
- o Bleeding disorders
- o Breast lump
- o Cancer
- o Chemical dependency
- o Chicken pox
- o Depression/anxiety
- o Diabetes
- o Emphysema
- o Epilepsy
- o Eye condition
- o Fibromyalgia
- o Fractures
- o Gall bladder Disease
- o Gout
- o Headaches
- o Heart/Vascular Disease
- o Hepatitis
- o Hernia
- o Herniated disk
- o High blood pressure
- o High cholesterol
- o Kidney Disease
- o Liver Disease
- o Lupus
- o Lyme Disease
- o Miscarriage
- o Multiple Sclerosis
- o Neurological Condition
- o Osteoporosis
- o Pacemaker
- o Parkinson’s Disease
- o Pinched Nerve
- o Polio
- o Prostate Problems
- o Prothesis
- o Psychiatric Illness
- o Scoliosis
- o Skin disorders
- o Stroke
- o Thyroid problem
- o Tuberculosis
- o Ulcers
- o Urinary Tract Infection

Surgery

- o Abdominal/Gastrointestinal
- o Back Surgery
- o Cardiovascular Procedure
- o Gynecological
- o Joint Procedure
- o Neck Surgery
- o Prostate
- o Skin Procedure

Allergies

- o Environmental
- o Food
- o Latex
- o Medications
- o Seasonal

Social History (Please circle)

Caffeine: Never Moderately Frequently **Tobacco:** Never Moderately Frequently

Alcohol: Never Moderately Frequently **Stress:** Never Moderately Frequently

Exercise: Never Moderately Frequently

Family History

- o Arthritis
- o Heart Problems
- o Thyroid
- o Cancer
- o High Blood Pressure
- o Cholesterol
- o Psychiatric

Medications & Substance Use/Exposure

- o Alcohol
- o Intravenous (IV) drugs/medications
- o Second hand smoke
- o Inhaled drugs/medications
- o Occupational
- o Oral drugs/medication: _____

Occupational Activities:

- Administration
- Construction
- Health care
- Household
- Business owner
- Daycare/childcare
- Heavy equipment operator
- Light manual labor
- Clerical/secretarial
- Executive/legal
- Heavy manual labor
- Manufacturing
- Computer IT
- Food service industry
- Home services
- Medium manual labor

Daily Activities

Sitting: Never Moderately Frequently **Standing:** Never Moderately Frequently

Walking: Never Moderately Frequently Bending: Never Moderately Frequently

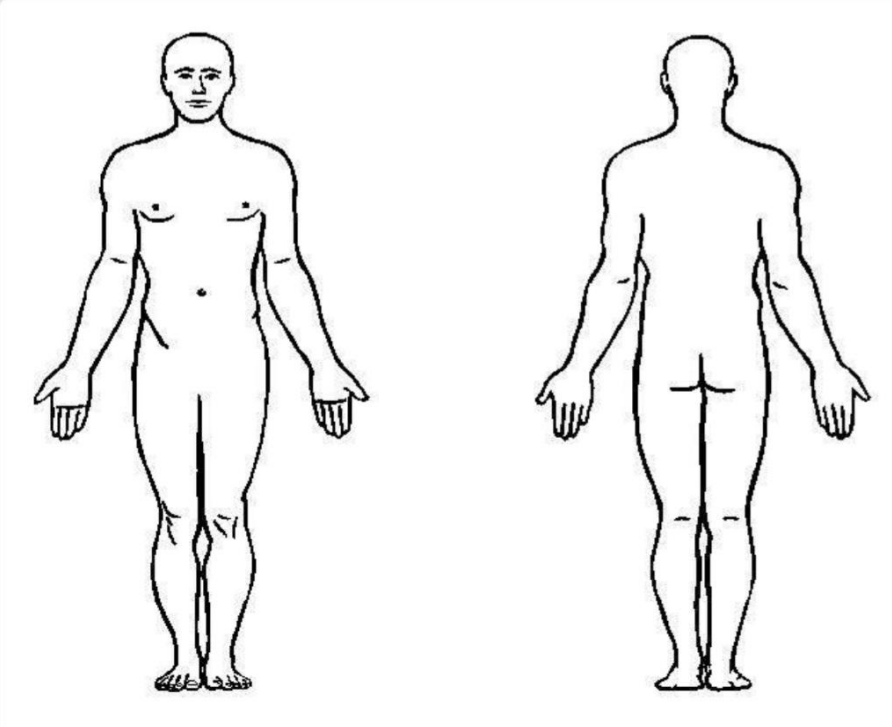
Light Lifting: Never Moderately Frequently**Operate Machinery:** Never Moderately Frequently

Heavy Lifting: Never Moderately Frequently **Overhead Work:** Never Moderately Frequently

Reaching: Never Moderately Frequently **Computer Use:** Never Moderately Frequently

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

#: Numbness **X:** Burning **/:** Stabbing **O:** Pins & Needles **+:** Dull ache



Describe your symptoms:
_____
_____
_____

When did your symptoms start? Month:_____ Day: _____ Year:
_____

How did your symptoms begin?
_____

Is your condition due to an accident?

- o Yes
- o No

Type of Accident

- o Auto
- o Work
- o Home
- o Other

To whom have you reported your accident?

- o Auto insurance
- o Employer
- o Workers compensation
- o Other
- o Attorneys Name: _____

How often do you experience your symptoms?

- o Constantly (76-100% of the day)
- o Frequently (51-75% od the day)
- o Occasionally (26-50% of the day)
- o Intermittently (0-26 % of the day)

What describes the nature of the your symptoms:

- o Sharp
- o Burning
- o Dull ache
- o Tingling
- o Numb
- o Stabbing
- o Shooting

How are your symptoms changing?

- o Getting Better
- o Not changing
- o Getting Worse

During the past 4 weeks, indicate the average intensity of your symptoms (o= None to 10= unbearable)

- o 0 (none)
- o 4
- o 8
- o 1
- o 5
- o 9
- o 2
- o 6
- o 10 (unbearable)
- o 3
- o 7

During the past 4 weeks, how much has the pain interfered with your normal work (including both work outside the home and housework)

- o Not at all
- o A little bit
- o Moderately
- o Quite a bit
- o extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- o All the time
- o Most of the time
- o Some of the time
- o A little of the time
- o None of the time

In general, would you say your overall health right now is:

- o Excellent
- o Very good
- o Good
- o Fair
- o Poor

Who have you seen for your symptoms:

- o No one
- o Other chiropractor
- o Medical doctor
- o Physical therapist
- o Other

What treatment did you receive for your symptoms?

- o Adjustments
- o Physical therapy
- o Medication
- o Surgery
- o Other

When did you receive this treatment?

- o In the last month
- o 2-3 months ago
- o 3-6 months ago
- o 6 months to 1 year ago
- o 1-2 years ago
- o 2-5 years ago
- o 5-10 years ago

What tests have you had for your symptoms?

- o Xrays
- o MRI
- o CT SCAN
- o OTHER

When were the tests done?

- o In the last month
- o 2-3 months ago
- o 3-6 months ago
- o 6 months to 1 year ago
- o 1-2 years ago
- o 2-5 years ago
- o 5-10 years ago

Have you had similar symptoms in the past?

- o Yes
- o No

If you have had or received treatment in the past for the same or similar symptoms, who did you see?

- o This office
- o Other chiropractor
- o Medical doctor
- o Physical therapist
- o Other

What is your occupation?

- o Professional/Executive
- o White Collar/ Secretarial
- o Trades
- o Laborer
- o Homemaker
- o Full-time student
- o Retired