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?
_____

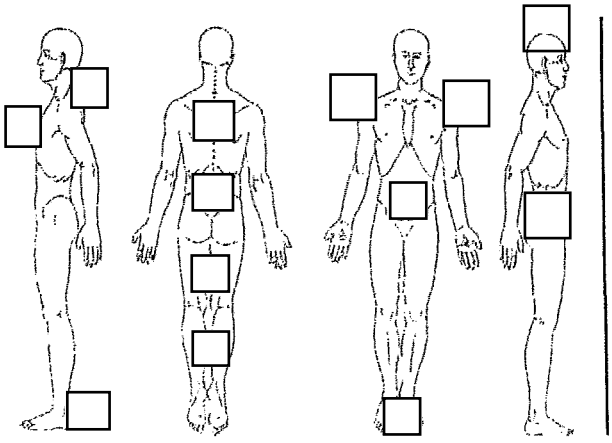
5 CURRENT PATIENT CONDITION

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

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
Get 6-8 hours of sleep nightly?	☐	☐
In a supportive relationship?	☐	☐
Take vacations?	☐	☐
Eat out more than 3 times/week?	☐	☐
History of abuse?	☐	☐
Major life trauma in past 3 years?	☐	☐
Drink alcohol? Drinks/day? _____	☐	☐
Use tobacco? Packs/day? _____	☐	☐
How many years? _____	☐	☐
Use recreational drugs?	☐	☐
Treated for substance abuse?	☐	☐

	Yes	No
Wake-up refreshed?	☐	☐
Enjoy your work?	☐	☐
Spend time outside?	☐	☐
Eat 3-6 meals daily?	☐	☐
Go on a diet more than twice/yr?	☐	☐
Watch TV? Hours/day? _____	☐	☐
Read? Hours/day? _____	☐	☐
Drink coffee?	☐	☐
Drink tea?	☐	☐
Drink soda/cola?	☐	☐
Add sugar/salt to food?	☐	☐