Back on Track Chiropractic

3335 South Airport Road W., Ste. 6A, Traverse City, MI 49684
Phone (231) 922-0421 www.backontrackmi.com

Please fill out this form as completely and accurately as possible.

❑ New Patient
❑ RE-PAT

Today's Date ______________________________ Patient File # ____________________

PERSONAL DATA

Name____ Age _________ Date of Birth __________________
Parents' names (if you are under 18) ____
Home Address______________________________ City _________________ State______ Zip ___________
Home Phone (______) _______________________ Business Phone (______) __________________________
Cell Phone (______) ___________________ E-Mail Address____
Occupation_________________________ Employer ____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name:____
Names and ages of children ____
Who may we thank for referring you to our office? ______________________________________

HEALTH INFO

Purpose of this appointment: ____
Have you had chiropractic care before? ❑ Yes ❑ No
How was your experience? ____
Are you currently begin treated by another doctor? ❑ Yes ❑ No
If Yes, Who are you seeing? ____
Are you taking any medication? ❑ Yes ❑ No
If Yes, What are you taking? ____
Have you had any surgery? ❑ Yes ❑ No
If Yes, please Explain: ____
Describe your present complaint: ____
Is your visit the result of a fall or accident? ❑ Yes ❑ No
Date of fall or accident: ________________
Explain in detail how the fall of accident happened: ____
____
____

Additional patient comments:
____
____

FOR WOMEN ONLY

Are you pregnant? ❑Y ❑N Possible/Unknown
If pregnant due date?_________ Name of OBGYN or Midwife:________________
If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.
Signature:____ Date:________________________

PHYSICAL INFO

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

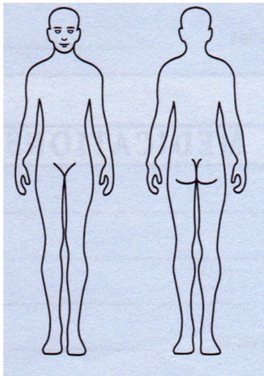
Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms, or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

Primary Health Concern:____



○ Please indicate the location of your pain or discomfort on the diagram.
○When did this problem start? ______________________________
○Have you ever had this problem before? □No □Yes If yes, when__________________________
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram to the left.
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? ____________Worse?_________
○What have you done to treat this problem? ________________________

Office Use Only:

I hereby certify that the information provided is true and accurate.

Patient Signature: ____ Date: ___________________________

WEBSITE SUBSCRIPTION

Email ____

If you would like, we can use your email to send you office information like changes to office hours or unexpected closings and also send occasional health related emails. Please check the appropriate box to indicate what level of communication you would like.

❑ I would like to receive both office information and health related emails.

❑ I would prefer to only receive emails about office information (office closings, changes to hours, etc.)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I acknowledge that Back on Track Chiropractic's "Notice of Privacy Practices" has been provided to me. I understand that I have a right to review Back on Track Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Back on Track Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practices for Back on Track Chiropractic is also provided on request at the main administration desk of this practice and on Back on Track Chiropractic's website at www.backontrackmi.com.

Back on Track Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Back on Track Chiropractic's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Signature of Patient or Personal Representative Date

____

Printed Name of Patient or Personal Representative Relationship of Representative