Office of Dr. Bradley Backhaus, D.C.

Patient Information:

Name ____ Age______ Date of Birth_____________________
Address____ City/State/Zip_________________________
Phone___________________________ Sex____________ Marital Status___________________________
Social Security #_________________________ Driver's License #_________________________________
Email____
Occupation_____________________________ Patient's Employer_________________________________
Work Address____ Work Phone___________________
Insurance Company____ Phone_________________________
Insured's Name______________________________________ Insured's Date of Birth_________________
Insured's ID # or S.S.#__________________________________
Spouse's Name__________________________________ Spouse's Occupation______________________
Spouse's Employer________________________________ Spouse's Work Phone____________________
Spouse's Insurance Co.______________________________________ Phone________________________
Spouse's Social Security #________________________________

Personal Health History:

Have you been to a chiropractor before? Yes__ No__
Explain:____
Who referred you to our practice? Person:___________________ Advertisement:___________________
Are you, or might you be pregnant? Yes__ No__ Do you have a pacemaker? Yes__ No__
Please list current medications, vitamins, minerals, supplements, herbs: _________________________
____
____
List any known allergies:____
When was your last physical?______________________ Results:___________________________________
Smoke: Yes__ No__ *Alcohol: Yes__ No__ Daily/Weekly/Social *Caffeinated drinks per day:________
Family Health History:____
____
List all significant previous injuries (sprains, fractures, accidents, etc.):___________________________
____
____
List all significant previous surgeries:____
____
____
List your usual forms of exercise and sports, including frequency:_________________________________
____

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Chief Complaint:

Reason for seeking care:____

____

Cause of condition (circle): auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/gradual other explain:____

When did your condition begin?____

Have you had anything like this before? Yes__ No__ Explain:___________________________________

Has the accident been reported? Yes__ No__ Employer__ Auto Insurance__ Other_______________

List any other professional seen for this:____

List any diagnosis and type of treatment:____

Have you been treated for any health condition by a physician in the last year? Yes__ No__

Explain:____

What makes it feel better?____

What makes it feel worse?____

Does the pain radiate (travel)? Where?____

At what time of day or setting (home, work, recreation) is your pain the worst?___________________

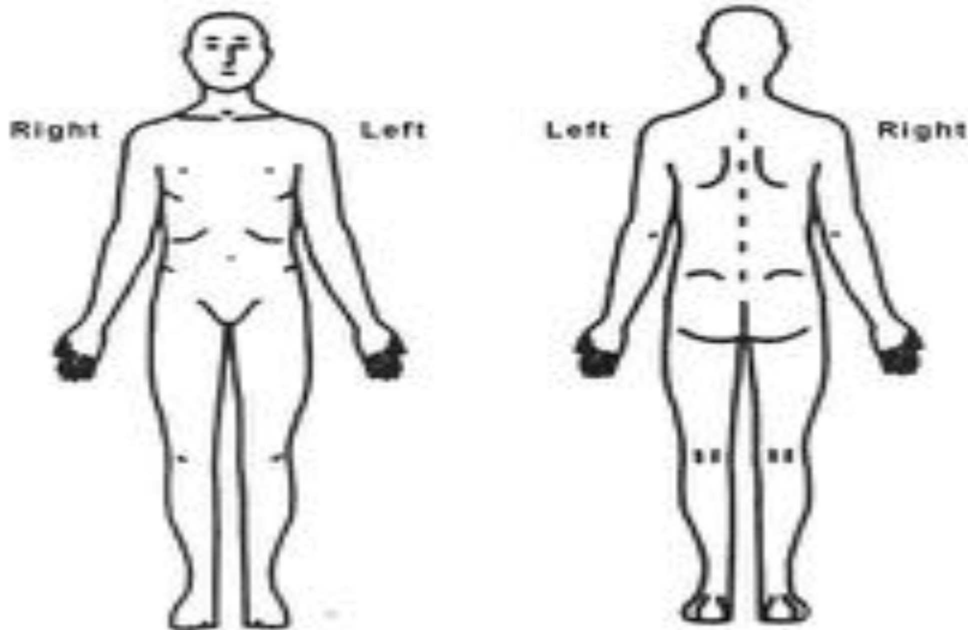
Is the condition interfering with work?________ Sleep? ________ Routine? ________ Other? _______

Has the pain been (circle): getting better getting worse staying the same

Please circle the degree of pain, 0 = none, 10 = severe pain 0 1 2 3 4 5 6 7 8 9 10

Using the following symbols, mark on the picture where you feel pain:

Numbness = = **Dull Ache** OO **Burning** XX **Sharp/Stabbing** // **Pins, Needles** ++ **Tension/Tightness** ^^



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Review of Systems: Please mark each item below for each sign/symptom you presently have or previously had:

GENERAL

__Convulsions/Seizures
__Frequent or recurring dizziness
__Frequent or recurring chills
__Fainting
__Vertigo
__Headache/Migraines
__Anxiety/Panic Attacks
__Recent Weight Loss/Gain
__Depression
__Frequent or recurring sweats
__Frequent or recurring hives/rashes
__Frequent or recurring cold/flus
__Fears/Phobias
__Bruise easily

EYES, EARS, NOSE, THROAT

__Frequent or recurring sore
__Deafness
__Ear noises
__Ear problems/infections
__Dental problems
__Sinus problems
__Nose blockage
__Frequent or recurring nose bleeds
__Vision problems
__Pain behind eyes

MUSCULOSKELETAL

__Low back problems
__Neck problems
__Upper/mid back problems
__Pain between shoulder blades
__Spinal curvature
__Shoulder problems R/L
__Arm problems R/L
__Hand problems R/L

MUSCULOSKELETAL CONT.

__Hip problems R/L
__Leg problems R/L
__Foot problems R/L
__Arthritis/Gout
__Fibromyalgia
__Swollen/painful/stiff joints
__Fractures
__Weak muscles
__Walking problems

CARDIOVASCULAR

__High blood pressure
__Heart attack
__Pain over heart
__Poor circulation/ankle swell
__Heart disease
__Rapid heart beat
__Palpitations
__Strokes
__Cold hands/feet
__Varicose veins

RESPIRATORY

__Asthma
__Chronic cough
__Difficulty breathing
__Spitting blood
__Spitting phlegm
__Wheezing

GASTROINTESTINAL

__Belching, bloating, gas
__Colon problems
__Constipation
__Diarrhea
__Excessive hunger/thirst
__Gall bladder problems
__Hemorrhoids
__Liver problems

GASTROINTESTINAL CONT.

__Nausea/vomiting
__Abdominal pain
__Ulcer
__Poor appetite
__Black or bloody stool
__Loss of bowel control

GENITO-URINARY/ENDORCINE

__Blood in urine
__Frequent urination
__Painful urination
__Kidney problems
__Prostate problems
__Loss of bladder control
__Thyroid problems

WOMEN ONLY

__Birth control___________
__Hormone replacement
__Cramps, backaches
__Excessive flow
__Hot flashes
__Irregular cycle
__Miscarriage
__Painful menstruation
__Vaginal discharge
__Breast pain
Pregnant at this time Y/N

OTHER

__Psoriasis
__Sexually transmitted disease
__HIV
__Pneumonia
__Sexual abuse
__Alcohol/drug addiction
__Anemia
__Cancer
__Hepatitis

I hereby certify that the statements and answers given on these forms are accurate to the best of knowledge and understand it is my responsibility to inform of health changes.

Patient Signature____ Date_____________________

If you have any special studies (MRI, X-ray, etc) please make plans to bring them and/or results to your first visit. If you would like a report written to your primary care physician discussing your condition and treatment plan, please provide name and information below.

Physician____________________________Address____