PATIENT INFORMATION FORM

PI ACUPUNCTURE CASH WC PT CHIROPRACTIC

Referring Doctor_____ Treating Doctor_____

First Name _____ M.I.___ Last Name _____

Birth Date ____/____/____ Age ____ SS#_____-_____-_____ Male____ Female_____

Marital Status_____ Spouse Name_____ DL#/STATE_____

Address _____ City _____ State_____

Zip _____ Home Phone_____ Wk Phone_____

Cell Phone _____Circle Best Contact Phone Number: Home Work Cell

Email _____ Employer _____

Referred By _____ Primary Doctor _____

Primary Insurance Co. Name & ID_____

Secondary/ Other Insurance Co. _____

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

If the insurance company pays me directly I will bring the payment for the treatments along with an explanation of benefit endorsed by my signature to this office promptly.

Patient Signature _____ Date _____/_____/_____

I hereby request and consent to physical therapy and/or chiropractic and/or acupuncture treatment for me (or my legal charge) provided by the providers at Back To Wellness. I do not expect the provider to be able to anticipate and explain all known risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure, which, the provider determines is in my best interest. I understand that there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. .I may request another person of my choice to be present in the treatment room during treatment.

Patient Signature _____ Date _____/_____/_____

New Patient Intake Form

Today's Date_____/_____/_____

Have you had Acupuncture Before? ☐ Yes ☐ No Herbal Medicine? ☐ Yes ☐ No

Reason for Visit Today_____

How long have you had this condition?_____ Is it getting worse? ☐ Yes ☐ No

Does it bother your ☐ Sleep ☐ Work ☐ Other (what?) _____

What seemed to be the initial cause?_____

What seems to make it better?_____

What seems to make it worse?_____

Are you under the care of a physician now? ☐ Yes ☐ No If yes for what?_____

Who is your physician? _____ Physician's phone_____

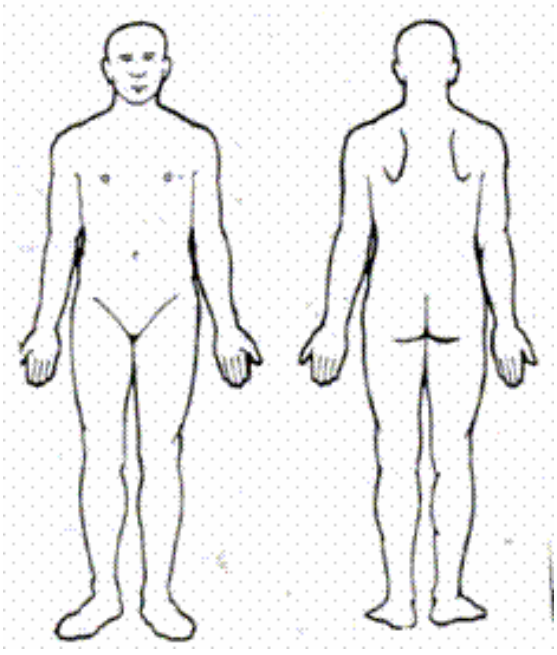
Other concurrent therapies_____

Pharmaceuticals taken past 2 months_____

Other Supplements taken past 2 months_____

Family Medical History

☐Allergies	☐ Cancer
_____	_____
_____	_____
☐Diabetes	☐Seizures
☐Heart disease	☐ Stroke
☐ High blood pressure	



Ache	Numbness	Pins & Needles	Burning	Stabbing
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Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

☐ AIDS/HIV	☐ Diabetes	☐ Multiple Sclerosis
☐ Tuberculosis	☐ Alcoholism	☐ Emphysema
☐ Measles	☐ Mumps	☐ Typhoid Fever
☐ Allergies	☐ Epilepsy	☐ Pacemaker
☐ Seizures	☐ Ulcers	☐ Appendicitis
☐ Goiter	☐ Pleurisy	☐Stroke
☐ Arteriosclerosis	☐ Heart disease	
☐ High blood pressure	☐ Thyroid disorder	☐ Gout
☐ Chicken Pox	☐ Whooping cough	☐ Polio
☐ Scarlet Fever	☐ Pneumonia	☐ Asthma
☐ Cancer	☐ Rheumatic fever	
☐ Herpes	☐ std	☐ Hepatitis
☐ Other (please specify)	☐ Surgery	☐ Major Trauma
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Lifestyle

☐ Alcohol	☐ Marijuana	Stress	Regular exercise	
☐ Tobacco	☐ Drugs	Occupational Hazards	Type_____	Frequency_____
			Type_____	Frequency_____

General Symptoms

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands & feet	☐ Night Sweats	☐ Peculiar tastes (describe)
☐ Strongly like cold drinks	☐ dream disturbed sleep	☐ Poor circulation	☐ Sweat easily	_____
☐ Strongly like hot drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps	_____
☐ Recent weight loss/gain	☐ Lack of strength	☐ Fever	☐ Vertigo or dizziness	_____

Head, Eyes, Ears, Nose, Throat

☐ Glasses
☐ Eye strain
☐ Eye Pain
☐ Red Eyes
☐ Itchy Eyes
☐ Spots in eyes
☐ Poor vision
☐ Blurred vision

☐ Night blindness
☐ Glaucoma
☐ Cataracts
☐ Teeth Problems
☐ Grinding teeth
☐ TMJ
☐ Facial Pain
☐ Gum Problems

☐ Sores on lips or tongue
☐ Dry Mouth
☐ Excessive saliva
☐ Sinus problems
☐ Excessive phlegm
Color of phlegm _____

☐ Recurrent sore throat
☐ Swollen glands
☐ Lumps in throat
☐ Enlarged thyroid
☐ Nose bleeds
☐ Ringing in ears
☐ Poor hearing
☐ Earaches

☐ Headaches
☐ Migraines
☐ Concussions
Other head or neck problems
_____
_____
_____
_____

Respiratory

☐ Difficulty breathing when lying down
☐ Shortness of breath

☐ Tight chest
☐ Asthma/wheezing

☐ Cough
Wet or dry?_____
Thick or thin?_____

☐ Coughing blood
☐ Pneumonia

Cardiovascular

☐ High blood pressure
☐ Blood clots

☐ Low blood pressure
☐ Fainting

☐ Chest pain
☐ Difficulty breathing

☐ Tachycardia
☐ Heart palpitations

☐ Phlebitis
☐ Irregular heartbeat

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating

☐ Diarrhea
☐ Constipation
☐ Laxative use
☐ Black stools
☐ Bloody stools
☐ Mucous in Stool

☐ Intestinal pain or cramping
☐ Itchy anus
☐ Burning anus
☐ Rectal pain
☐ Hemorrhoid
☐ Anal Fissures

Bowel movements

Frequency _____
Color _____

☐ Bad Breath

Musculoskeletal

☐ Neck/shoulder pain
☐ Muscle pain

☐ Upper back pain
☐ Low back pain

☐ Joint pain
☐ Rib pain

☐ Limited range of motion
☐ Limited use

☐ Other (describe)
_____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations

☐ Eczema
☐ Psoriasis
☐ Acne

☐ Dandruff
☐ Itching
☐ Hair loss

☐ Change in hair/skin texture
☐ Fungal infections

Other hair/skin problems
_____
_____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics

☐ Poor memory
☐ Depression
☐ Anxiety

☐ Irritability
☐ Easily Stressed

☐ Considered/attempted suicide
☐ Seeing a therapist

Other (specify)
_____

Genito-Urinary

☐ Pain on urination
☐ Frequent urination
☐ Urgent urination

☐ Blood in Urine
☐ Unable to hold urine
☐ Incomplete urination

☐ Venereal disease
☐ Bedwetting
☐ Wake to urinate

☐ Increased Libido
☐ Decreased Libido
☐ Kidney stone

☐ Impotence
☐ Premature ejaculation
☐ Nocturnal emission

Gynegology

Age Menses began _____

Length of cycle (day 1 to 1)

Duration of flow _____
☐ Irregular periods
☐ Painful periods
☐PMS

☐ Vaginal discharge (color)_____
☐ Vaginal sores
☐ Vaginal odor
☐ Clots

☐ Breast lumps
pregnancies_____
☐ Live births_____
☐ Premature births____.
Age at Menopause_____

☐ Date of last PAP
_____

Date last period began
_____

Other_____

Stop Here

Pulse:_____ Tongue_____

Other:_____

Dx: _____

Points_____

_____

Tx Plan: _____/ Week ☐Based on medical necessity ☐As prescribed by PTP ☐As long as symptoms ☐Maintenence

Modalities: ☐Acupuncture ☐E-Stim ☐I/R ☐Mech. Tract. ☐Man Therapy ☐Cupping ☐Ther/exer

Short term goals: ↓Mms Spasm ↓ Inflammation ↑ROM ↓Pain

Long term goals: ↑Function ↑Strength ↑Balance ↑Stability

Herbs/Formulas:_____

Refer to ☐ Chiro ☐Ortho ☐ Neuro ☐ Internist ☐ Opth ☐ Other_____