For Your Convenience, Please Fill This Form Out Online,
Then Print It And Bring With You To Your First Appointment.

Alternative Back Care Clinic, PC

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Please fill out this form online and then print it. Please bring this form to your first appointment. Thank you.

ABOUT YOU

Today's Date:
First Name: Middle: Last:
What you prefer to be called: Male ◯ Female ◯
Birth Date: Age: SS#:
Home Address:
City: State: Zip:
Home Phone:
Cell Phone:
Email Address:
Referred By:
Employer: How Long:
Employer's Address:
City: State: Zip:
Occupation: Work Phone:
Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed
Spouse's Name:

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ◯ Yes ◯ No
If so, please explain:
The reason for this visit is a result of: ◯ Work ◯ Sports ◯ Auto ◯ Trauma ◯ Chronic
Explain what happened:
Please describe the pain and it's location:
When did the condition begin:
Is this condition getting worse? ◯ Yes ◯ No ◯ Constant ◯ Comes & Goes
Is this condition interfering with your: ◯ Work ◯ Sleep ◯ Standing ◯ Sitting ◯ Daily Routine
If so, please explain:
Have you had this or similar conditions in the past? ◯ Yes ◯ No
If so, please explain:
Have you been treated by a Medical Physician for this condition: ◯ Yes ◯ No
If so, where? Physician:

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relation? _____

Contacts Home Phone: _____

Contacts Work Phone: _____

Contacts Cell Phone: _____

HEALTH HISTORY

Are you taking any of the following medications?

◯ Nerve Pills ◯ Pain Killers (including Aspirin) ◯ Muscle Relaxers ◯ Stimulants

◯ Blood Thinners ◯ Tranquilizers ◯ Insulin ◯ Other _____

Mark the circles if you have you ever had any of the following diseases/medical conditions?

◯ Heart Attack / Stroke	◯ Heart Surgery/Pacemaker	◯ Heart Murmur
◯ Congenital Heart Defect	◯ Mitral Valve Prolapse	◯ Artificial Valves
◯ Alcohol / Drug Abuse	◯ Thyroid Problems	◯ Hepatitis
◯ HIV+/ AIDS	◯ Shingles	◯ Cancer
◯ Frequent Neck Pain	◯ Emphysema/Glaucoma	◯ Anemia
◯ High / Low Blood Pressure	◯ Psychiatric Problems	◯ High Cholesterol
◯ Severe / Frequent Headaches	◯ Kidney Problems	◯ Ulcers/Colitis
◯ Fainting/Seizures/Epilepsy	◯ Sinus Problems	◯ Asthma
◯ Diabetes/Tuberculosis	◯ Difficulty Breathing	◯ Chemotherapy
◯ Lower Back Pain	◯ Artificial Bones/Joints	◯ Arthritis

List any other serious medical condition(s) you have or ever had: _____

Please list anything that you may be allergic to: _____

List previous surgeries or treatments with dates: _____

List any past serious accidents with dates: _____

Do you smoke? ◯ No ◯ Yes / How much? _____ How long? _____

Are you wearing: ◯ Heel lifts ◯ Sole lifts ◯ Inner soles ◯ Arch supports

What is the age of your mattress? _____ Is it comfortable? ◯ Yes ◯ No

For women: Are you taking Birth Control? ◯ Yes ◯ No

Are you Pregnant? ◯ No ◯ Yes/How long? _____ Nursing? ◯ Yes ◯ No

DISCLOSURE

- We invite you to discuss any questions you may have with our services. The best health services are based on a friendly, mutual understanding between providers and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. If your account is not paid within 90 days of the date of service and not financial arrangements have been made, you will be responsible for any expenses incurred in collection of your debt at 15% APR.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____