BACK TO HEALTH CHIROPRACTIC & MASSAGE

315 N Washington, Suite 260 ● Cookeville, TN 38501 ● Phone (931) 372-2225 ● BACK2HEALTHCOOKEVILLE.COM

PLEASE HELP US PROVIDE RESPONSIBLE CARE BY COMPLETING THIS CONFIDENTIAL INTAKE FORM

DATE _____

NAME_____ SS#_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE _____ WORK PHONE_____

EMAIL _____

DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____

MALE☐ FEMALE☐ MARITAL STATUS: MARRIED☐ DIVORCED☐ WIDOWED☐ SINGLE☐

RACE_____ ETHNICITY_____ PREFERRED LANGUAGE_____

EMERGENCY CONTACT
NAME AND PHONE_____RELATIONSHIP_____

HOW DID YOU LEARN ABOUT BACK TO HEALTH CHIROPRACTIC & MASSAGE?_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?_____

WHAT MEDICAL CONDITIONS ARE YOU BEING TREATED FOR
CURRENTLY?_____

ARE YOU ALLERGIC TO ANY MEDICATIONS/FOODS/OILS/PERFUMES/OTHER? YES◯ NO◯
PLEASE LIST:_____

ANY PHYSICAL OR EMOTIONAL ISSUES WE MIGHT NEED TO KNOW ABOUT? ____YES____NO____NOT SURE

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

◯ ACCIDENT
◯ SPRAINS
◯ VARICOSE VEINS
◯ HIGH/LOW BLOOD PRESSURE
◯ MID BACK PAIN
◯ BROKEN BONES
◯ LOW BACK PAIN
◯ DECREASED RANGE OF MOTION
◯ GALLBLADDER PROBLEMS
◯ KIDNEY/URINARY/BLADDER FUNCTION
◯ NUMBNESS (WHEN/WHERE)_____
◯ THYROID DISEASE
◯ DIABETES
◯ HEADACHES
◯ DISC PROBLEMS
◯ FAINTING
◯ CURRENT PREGNANCY
◯ DEPRESSION
◯ BLOOD CLOTS
◯ BREAST AUGMENTATION
◯ WHIPLASH
◯ RASHES
◯ ARTHRITIS, BURSITIS OR GOUT
◯ COLITIS
◯ HEART DISEASE
◯ JOINT ACHE
◯ BRUISING EASILY
◯ RECENT CHANGES IN SENSES (HEARING,SMELL,VISION)
◯ NECK PAIN
◯ SEIZURES
◯ STROKE
◯ CANCER
◯ MIGRAINES
◯ NIGHT SWEATS

Past injuries can affect present health (please check all that apply and list when they occurred)

◯ FALLS / ACCIDENTS ◯ HEAD INJURIES ◯ FIGHTS ◯ SPORT INJURIES
◯ DISLOCATIONS ◯ EXTENSIVE DENTAL WORK ◯ BROKEN BONES ◯ LOSS OF CONSCIOUSNESS
◯ SURGERY (PLEASE LIST DATES AND TYPES OF SURGERIES)_____

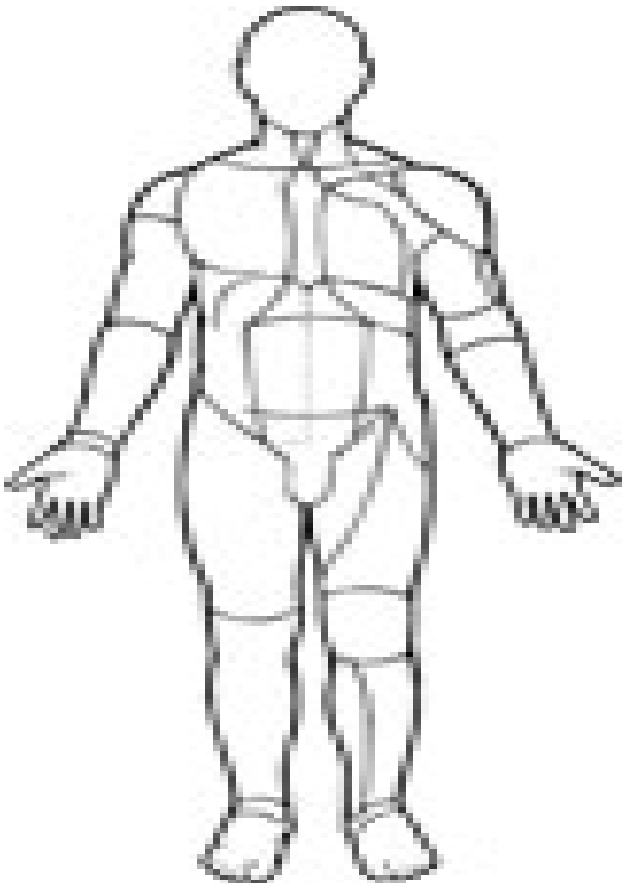
ANY FAMILY HISTORY OF HEART DISEASE, CANCER, DIABETES, OR STROKE? ◯ YES ◯ NO FAMILY MEMBER: _____
HAVE YOU HAD A MASSAGE OR CHIROPRACTIC CARE BEFORE? _____ IF YES, WHERE_____

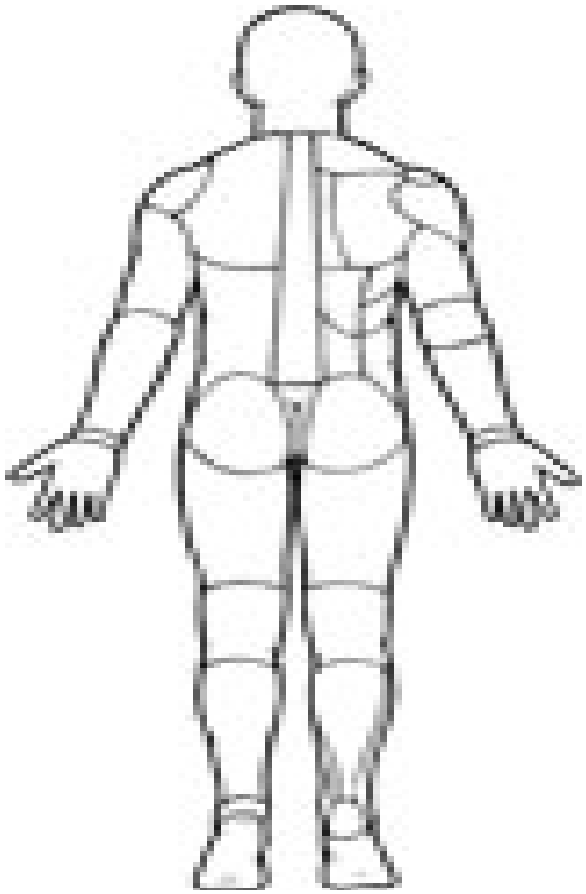
WHAT BRINGS YOU IN TODAY?_____

On a scale of 1 – 10 (1=Least, 10=Most) rate the severity of your current symptoms:

1 2 3 4 5 6 7 8 9 10

PLEASE CIRCLE THE PLACES ON THE DRAWINGS BELOW THAT YOU ARE FEELING DISCOMFORT.





Please check (√) all that applies to your pain.

Pain Quality:

☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Aching ☐ Throbbing ☐ Tingling ☐ Deep ☐ Cramping ☐ Numbness ☐ Radiating

What percentage of the day are you feeling pain? ☐ 0-20% ☐ 20-40% ☐ 40-50% ☐ 50-70% ☐ 70-90% ☐ 100% of the day

What part of the day is pain the worst? ☐ In the Morning ☐ At Midday ☐ At Day's End ☐ At Night or ☐ All Day

Pain the same or is aggravated by: ☐ Sitting ☐ Standing ☐ Bending ☐ Walking ☐ Stooping ☐ Laying on your back ☐ Lifting ☐ Sleeping ☐ Sneezing ☐ Coughing ☐ Straining ☐ Reaching ☐ Twisting ☐ Looking up ☐ Looking down ☐ Resting ☐ Driving ☐ Typing ☐ Scooping ☐ House Chores ☐ Exercise ☐ Lying on your stomach ☐ Stair Stepping

Pain is relieved by: ☐ Sitting ☐ Standing ☐ Laying down ☐ Knees Bent Up ☐ Support ☐ No Movement ☐ Movement ☐ Heat ☐ Ice ☐ Analgesic Topical ☐ Ibuprofen ☐ Medication ☐ Rest ☐ Stretching/Exercise ☐ Adjustments ☐ Massage

Information About Your Lifestyle

Are you active in any exercise and /or sport activities? ◯Yes ◯No

How would you rate your eating habits? ◯excellent ◯pretty good ◯could be better ◯needs improvement

Do you follow a specific nutritional program? ◯Yes ◯No If yes, please describe _____

Do you smoke cigarettes? ◯Yes ◯No If yes, How long have you smoked? _____How many cigarettes per day do you smoke? _____

Have you ever smoked tobacco products? ◯Yes ◯No Do you drink alcoholic beverages? ◯Yes ◯No Use drugs? ◯Yes ◯No

How well do you sleep? ◯excellent ◯pretty good ◯restless ◯cannot sleep

How is your energy level ◯great ◯okay ◯low ◯better in AM or PM

Do you wake up ◯full of energy ◯feeling rested ◯feeling tired ◯feeling exhausted ?

Do you feel your immune system is ◯strong ◯okay ◯low ◯improving ◯getting worse ?

Do you take nutritional supplements and/ or vitamins? ◯Yes ◯No

Brand name _____

Length of use _____

Women Only: Do you take ◯birth control pills ◯hormone replacement therapy?

Do you have difficulty with your menstrual cycles? ◯Yes ◯No

Information About You and Chiropractic

Have you ever been to a chiropractor before? ◯Yes ◯No If yes, who was the Chiropractor?

_____

Why did you seek Chiropractic care? _____

How long did you receive care? _____

What did you like / dislike about Chiropractic care? _____

What do you hope to receive from Chiropractic? _____

Have you had X-rays taken in the past? ◯Yes ◯No

The above is accurate to the best of my knowledge

_____ _____

Patient's Signature Date

***Please note that a payment is expected at time of service and we will be happy to provide you with an itemized statement of the care you received.**

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo Chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and an art which concerns itself with the relationship between structure (primarily the spine) and the function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. *Health* is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a *vertebral subluxation*. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an *adjustment*. An adjustment is the specific application of forces to correct and or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. "I have read and fully understand the above statements and therefore accept chiropractic care on this basis. "

_____ _____

Signature Date

INFORMED CONSENT FOR MASSAGE THERAPY/REFLEXOLOGY/REIKI/AESTHETICS

Thank you for choosing Back To Health Chiropractic & Massage for your care. Please read the following and sign below:

"I understand massage and reflexology are not replacements for medical care and no diagnosis will be made by the Therapist. I accept responsibility for seeking medical care through a qualified health care provider. If I experience any pain or discomfort I will immediately inform the Therapist so that the pressure or methods can be adjusted to my comfort level. This is a therapeutic massage/reflexology session and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. Being that massage/reflexology should not be done under certain medical conditions, I agree to keep the Therapist updated on any changes in my health profile and I release the Therapist from liability if I fail to do so."

_____ _____

Signature Date

PRIVACY PRACTICES

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Back To Health Chiropractic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____

Patient's Name (print)

_____

Patient's Signature Date