

BACK to BASICS
PATIENT INTRODUCTION FORM

Today's Date: _____, 20____
Name: _____ SS# _____
Address: _____ Apt# _____ Date of Birth: ___/___/____
City: _____ State: _____ Zip: _____ Gender: **(M)** **(F)**
Cell (____) _____ WK (____) _____ HM (____) _____
Employment Status **(EMPLOYED)** **(FULL-TIME STUDENT)** **(RETIRED)** **(UNEMPLOYED)**
Occupation: _____ Employer: _____
EMAIL: _____ Marital Status **(M)** **(S)** **(D)** **(W)** **(O)**
Women: Are you pregnant **(Y)** **(N)** Number of Children: ____
Activities/Sports/Hobbies: _____
How did you hear about us? **(Google)** **(Yelp)** **(Existing patient)** **(Other)** Explain: _____
Have you seen a Chiropractor before? **(Y)** **(N)**

IN CASE OF EMERGENCY

Contact Name: _____ Phone: (____) _____ Relationship: _____
Primary Care Physician: _____ Office Phone: (____) _____

MEDICAL HISTORY

(Check all that apply, past or present symptoms)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Stress	<input type="checkbox"/> Asthma
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Leg Cramps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Upper Backaches
<input type="checkbox"/> Weakness of Limbs	<input type="checkbox"/> Lower Backaches	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fatigue (AM) (PM)	<input type="checkbox"/> Digestive Problems
		<input type="checkbox"/> Stiff Neck

When did you symptoms begin? _____
Briefly describe your symptoms: _____
How did your symptoms start? _____
Are you taking any medications? List: _____
Are you taking any supplements? List: _____
List any accidents/traumas/surgeries: _____
Is there a family history of: Cancer Heart Disease Diabetes Other: _____
Do you have health insurance? **(Y)****(N)** Company? _____
Insurance Customer Service # (____) _____ Policy ID# _____ Grp# _____

I have read carefully and agree to the terms of the Financial and Cancellation Policy, Informed Consent and Terms of Acceptance of Back to Basics. I also agree to the terms that I am the said responsible party for my own payments due in receipt for my treatment with Back to Basics.

Patient Name Printed Patient Signature Date

If patient is a minor: I hereby give my consent and permission for _____ to be treated in this office and furthermore agree to the above aforementioned.

Guardian Name Printed Guardian Signature Date