Backstrom Chiropractic Clinic
496 Crescent Blvd.
Glen Ellyn · IL 60137
Phone 630·790·2440 · Fax 630·790·4202

Confidential Patient Health Records / Re-Examination

In accordance with the compliance regulations, it is necessary to update your patient information every 90 days. Please complete the following with as much detail as possible. Thank you.

Date: ___________________________

Please complete the following so we can make sure our records are up-to-date:

Name: ____

Address: ____

City: ____

State: ___________________ Zip: _______________

Date of Birth: _____________________

Family Status: Single ___ Married ___ Divorced ___ Widowed ___

Last 4 digits of your Social Security #: ___ ___ ___ ___ (for Electronic Health records)

E-mail: ____________________________________

Home Phone: _______________________________ Work Phone: ________________________________

Cell Phone: ________________________________ Cell Phone Carrier: ___________________________

Please provide your cell phone carrier to receive appointment reminders by text

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Communications

I authorize Backstrom Chiropractic Clinic staff to communicate and/or leave messages for me at the following locations and with the authorized person/s.

Authorized person's name and relationship to patient:

Name____ Relationship ________________

Home# _________________ Cell#_________________ Work#_________________

Name____ Relationship ________________

Home# _________________ Cell#_________________ Work#_________________

Patient Name: ________________________ Patient #: _____________________ Date: _____________

INITIAL EVALUATION
CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

My present symptoms are (list in order of importance):

Chief Complaint (enter only ONE location. Use next page for secondary complaint/location)
Symptom #1 Location: _________________________________

Associated Symptoms
Are there any other conditions or symptoms that may be related to your major complaint?
If yes, please explain ____
Are there any other unrelated health problems or symptoms?
If yes, please explain ____

Quality (circle what applies)
Symptoms Characterized As (circle what applies)
Aching, Burning, Constant, Cramping, Intermittent, Localized, Mild, Moderate, Painful to touch, Piercing, Severe, Sharp, Shooting, Stabbing, Throbbing, Other __________________________
Does the pain travel or radiate? ❑Into arm R or L ❑Into leg R or L ❑Other ___________________

Pain/Symptom Scale:
Rate the level of your pain/symptoms from 0, no pain/no symptoms, to 10, unbearable pain/symptoms:
Circle one: 0 1 2 3 4 5 6 7 8 9 10

Severity: How frequent is this condition? (circle what applies)
Acute, Chronic, Occasional, Persistent, Regular
Condition interferes: (circle what applies) w/eating, sleeping, work, vacuuming, cooking, cleaning, lifting, reaching overhead, exercise, other: ____

Duration
Date the symptom(s) first appeared: ____
Are your symptoms a result of an injury or accident? Yes No
Date of the accident/injury, if applicable: ____

Timing
Symptoms Onset: (circle what applies) Abrupt, Gradual onset, Recent onset, Sudden onset
My pain/symptoms started when: ____
Exacerbated by: (My pain/symptom gets worse with or when)
____
Improves: (My pain/symptom improves with or when):
____
Worse: (circle what applies) End of day, At night, In the morning, Later in the day, Various times

Context Mechanism of injury:
What activity were you doing when your symptoms began? ___________________________________

Modifying Factors:
General: None, Difficulty recovering
Previous Treatment: No previous treatment, Previously treated, Treated by another chiropractor, Treated by another physician

Use next page for additional symptoms and locations, if applicable

Patient Name: _________________________ Patient #: ______________________ Date: ______________

<u>Chief Complaint</u> (enter only ONE location. Inform our staff if you have other complaints/locations)
Symptom #2 Location: ___________________________________

<u>Associated Symptoms</u>
Are there any other conditions or symptoms that may be related to your major complaint?
If yes, please explain ____
Are there any other unrelated health problems or symptoms?
If yes, please explain ____

<u>Quality</u> (circle what applies)
Symptoms Characterized As (circle what applies)
Aching, Burning, Constant, Cramping, Intermittent, Localized, Mild, Moderate, Painful to touch, Piercing, Severe, Sharp, Shooting, Stabbing, Throbbing, Other ____________________________
Does the pain travel or radiate? ❑Into arm R or L ❑Into leg R or L ❑Other ____________________

Pain/Symptom Scale:
Rate the level of your pain/symptoms from 0, no pain/no symptoms, to 10, unbearable pain/symptoms:
Circle one: 0 1 2 3 4 5 6 7 8 9 10

<u>Severity</u>: How frequent is this condition? (circle what applies)
Acute, Chronic, Occasional, Persistent, Regular
Condition interferes: (circle what applies) w/eating, sleeping, work, vacuuming, cooking, cleaning, lifting, reaching overhead, exercise, other: ____

<u>Duration</u>
Date the symptom(s) first appeared: ____
Are your symptoms a result of an injury or accident? Yes No
Date of the accident/injury, if applicable: ____

<u>Timing</u>
Symptoms Onset: (circle what applies) Abrupt, Gradual onset, Recent onset, Sudden onset
My pain/symptoms started when: ____
Exacerbated by: (My pain/symptom gets worse with or when)
____
Improves: (My pain/symptom improves with or when):
____
Worse: (circle what applies) End of day, At night, In the morning, Later in the day, Various times

<u>Context</u> Mechanism of injury:
What activity were you doing when your symptoms began? _____________________________________

<u>Modifying Factors:</u>
General: None, Difficulty recovering
Previous Treatment: No previous treatment, Previously treated, Treated by another chiropractor, Treated by another physician

PAIN DRAWING

Name: ______________________________ Date: ___________________

Date symptoms began and/or date of injury: ______________________________

1. Please mark **area(s)** of injury or discomfort using the following symbols:

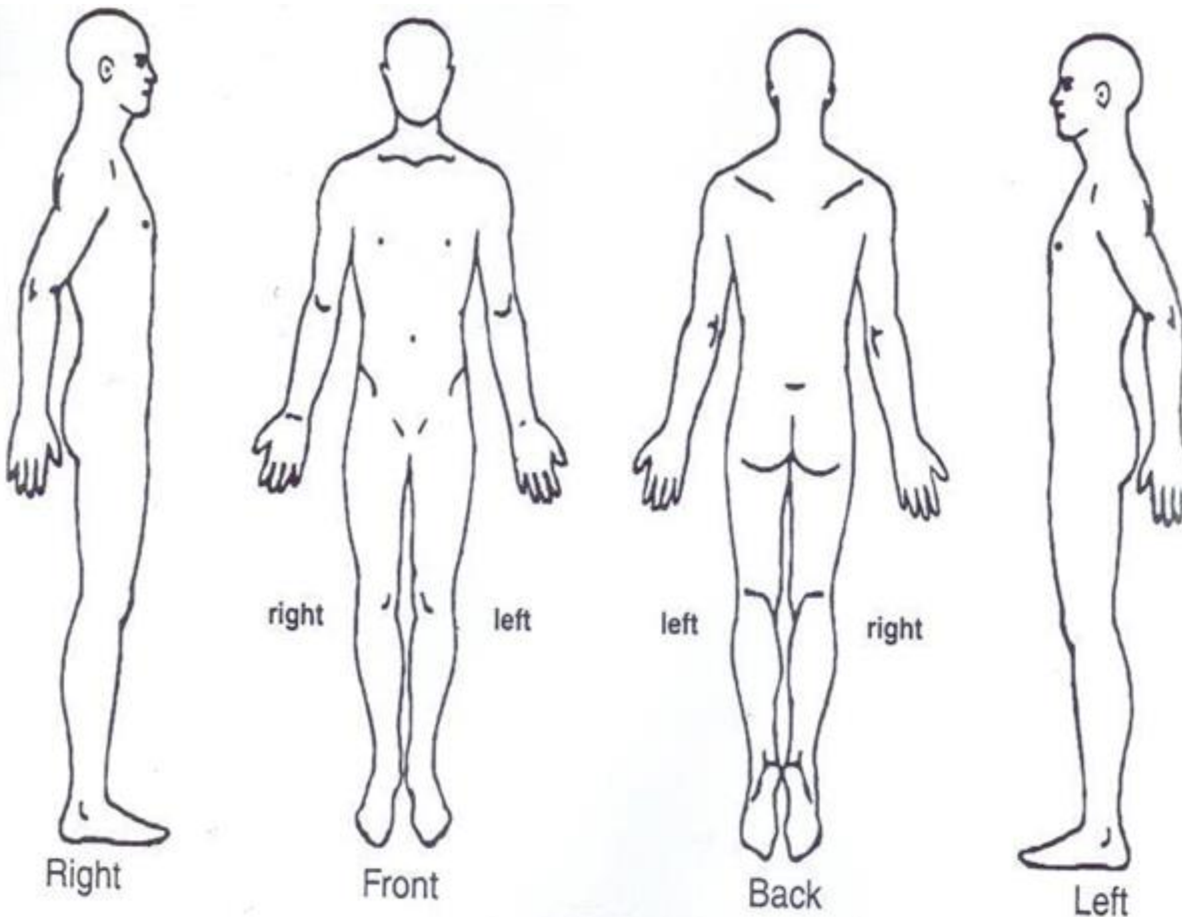
Type of pain:

Ache	Dull	Stiffness	Sharp	Stabbing	Shooting	Swelling	Cramping
A	D	S	SH	ST	SS	SW	C

Burning	Throbbing	Numbness	Tingling	Other ____________________
B	TH	N	T	

2. Indicate all scars from surgery or injury using the following symbol: ‡

3. Circle any area of pain not represented by a symbol.



On a scale of 0-10, please circle the level that most accurately represents your pain.
0 = No pain 10 = Unbearable Pain

Right Now	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10

Patient Name: ______________________________ Patient #: _________________________ Date: ____________

Medical History/Illnesses (Since your last visit)

____

____

Surgeries/Indicate Type and Date of Surgery (Since your last visit)

____

____

Treatments (Since your last visit)

____

____

Immunizations (Since your last visit)

All patients (65 years and older): Have you ever received a pneumonia vaccination? Y N

Injuries/Accidents (Since your last visit)

Description: Date:

____

____

OB/GYN History (Since your last visit)

Women (40-69 years): Date of last mammogram: ____________

Are you pregnant? ____ No ____ Yes Due Date ________________________

Family History	Diseases in the Family? (Rheumatoid arthritis, Heart Disease, Cancer, Diabetes, MS)	Living or deceased?
Mother		
Father		
Brothers		
Sisters		
Grandmother (maternal)		
Grandfather (maternal)		
Grandmother (paternal)		
Grandfather (paternal)		

Smoking Status **Check here if same as previous _____**

____ Never

____ Smoker ____ Lives with smoker Since age: ____

Current every day: ____ Current some day: ____

Former Smoker: ____ Date Quit: ___________

____ Cigarettes ____ Cigar ____ Pipe _____ Chews ____ Dips

PRESCRIPTION MEDICATIONS **Check here if same as previous _____**

Current Medications **Dosage in mg.** **Times per day**

______________________ ___________________________________

______________________ ___________________________________

______________________ ___________________________________

______________________ ___________________________________

Allergies Please indicate any allergies you have to any Medications (Prescription Drugs):

Check here if same as previous _____

Medication: Reaction:

______________________ ____

______________________ ____

______________________ ____