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

Confidential Patient Health Records

PATIENT INFORMATION **Patient #: _____ Date: _____**

Name: _____ Name of Spouse: _____

Address: _____

City: _____

State: _____ Zip: _____

Date of Birth: _____ Age: _____

Sex: ____ Female ____ Male Race: Caucasian ___ Hispanic ___ Other: _____

Last 4 digits of your Social Security #: ___ ___ ___ ___ (required for Electronic Health Record creation and patient access)

Family Status: ___Single ___Married ___Divorced ___Widowed # of children ____

Referred to this office by: _____

E-mail: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____

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

EMPLOYMENT INFORMATION

Employment Status: ___ Employed ___ Part-time Student ___ Full-Time Student Other_____

Occupation: _____ Employed by: _____

INSURANCE INFORMATION

Primary Health Insurance Carrier: _____ ID#: _____ Group #_____

Insured's Name: _____ Insured's Date of Birth: _____

Secondary Health Insurance Carrier: _____ ID#:_____ Group #_____

Insured's Name: _____ Insured's Date of Birth: _____

Who is responsible for your bill? ___ Self-Pay ___ Spouse ____ Parent (Guardian)

___ Auto Insurance ___Worker's Comp

___ This is **NOT** a Work-Related or Worker's Compensation injury

___ This is **NOT** an Auto Accident related injury

___ This is **NOT** a Personal Injury case currently under litigation

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

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: _____

Chief Complaint (enter only ONE location. Inform our staff if you have other complaints/locations)
Symptom #2 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)
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Duration
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Improves: (My pain/symptom improves with or when):
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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
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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:

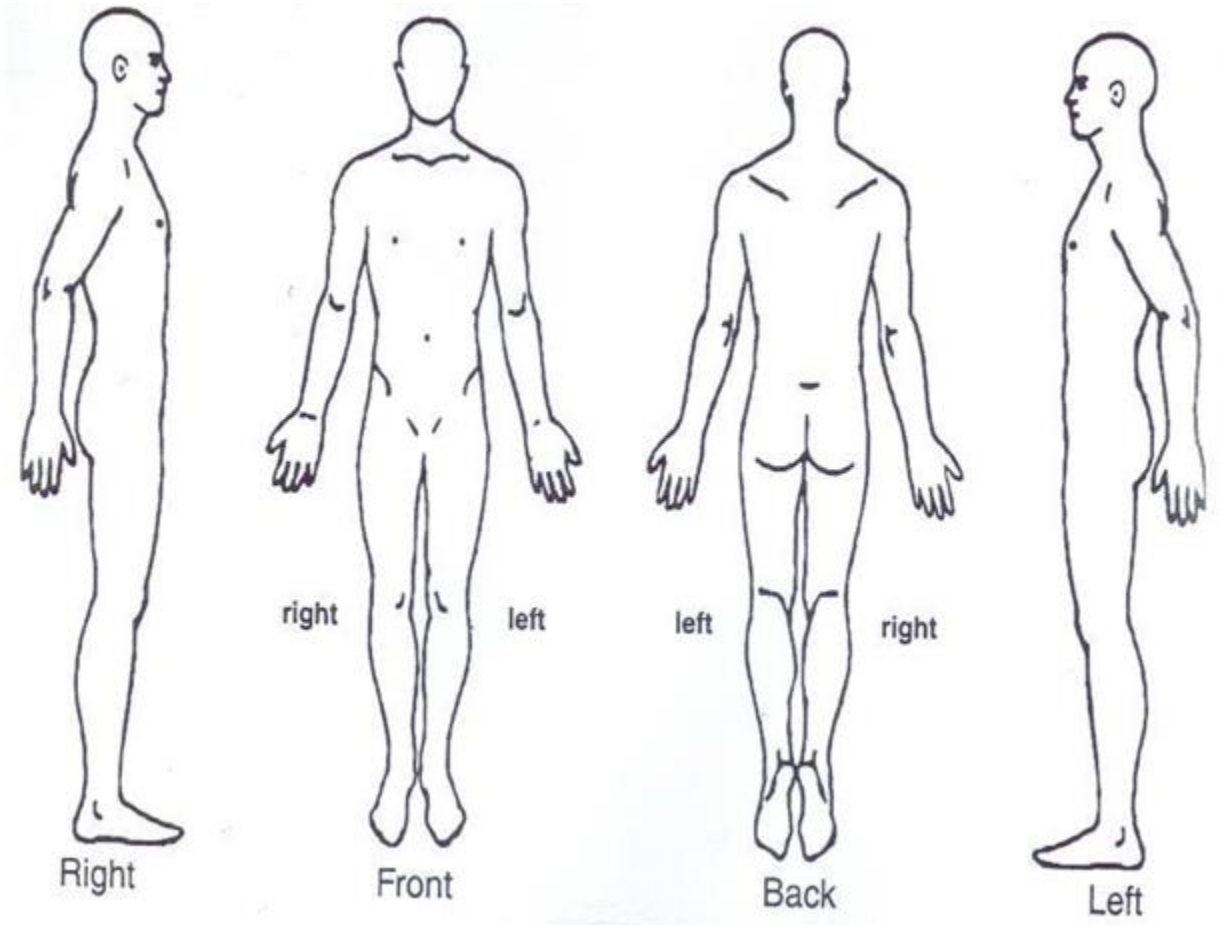
Type of pain:

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

_____

_____

Surgeries/Indicate Type and Date of Surgery

_____

_____

Treatments (chiropractic, physical therapy, etc.)

_____

_____

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

Injuries/Accidents

Description: Date:

_____

_____

OB/GYN History

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

____ Never

____ Smoker ____ Lives with smoker Since age: ____

Current every day: ____ Current some day: ____

Former Smoker: ____ Date Quit: _____

____ Cigarettes ____ Cigar ____ Pipe _____ Chews ____ Dips

PRESCRIPTION MEDICATIONS Dosage in mg. Times per day

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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

Medication: Reaction:

_____ _____

_____ _____

_____ _____