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: _____________
Incident: ____ [office use only]

RE-EVALUATION
CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS

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

Chief Complaint
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)
Improvement (circle what applies) None, Improving
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, Household Activities, Normal Lifestyle, School, Sleeping, Work

Duration
Date the symptom(s) first appeared: _____________
Are your symptoms a result of an injury or accident?
If yes, what is the date of the accident/injury? ___________

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: (My pain is worse) 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

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)

Improvement (circle what applies) None, Improving

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, Household Activities, Normal Lifestyle, School, Sleeping, Work

Duration

Date the symptom(s) first appeared: ______________

Are your symptoms a result of an injury or accident?

If yes, what is the date of the accident/injury? ____________

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: (My pain is worse) 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

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:

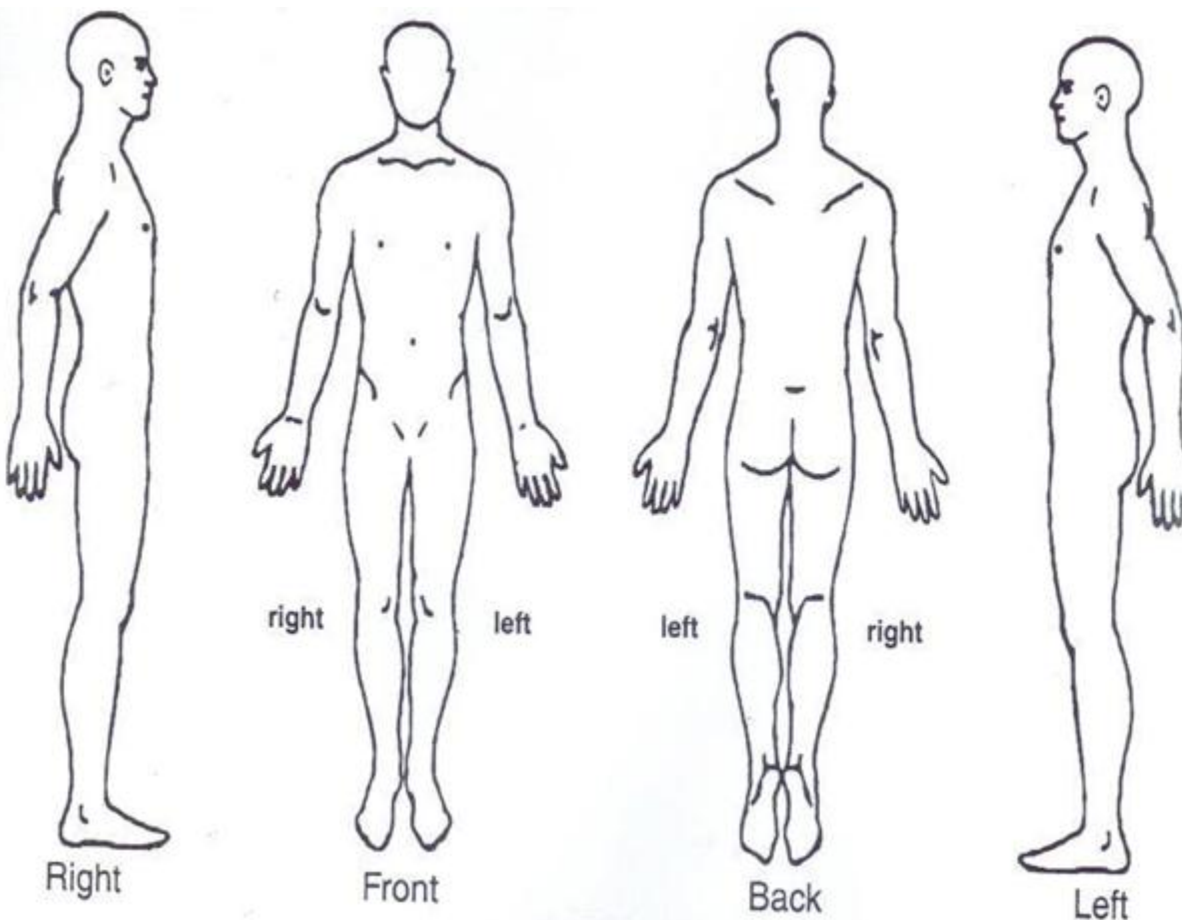
Type of pain:

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: