Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name:	Last Name:	Date:
[redacted]	DOB:	Sex: ○ M ○ F
Marital Status:	# of Children:	Occupation:
Street Address:		Height:
City, State, Postal Code:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

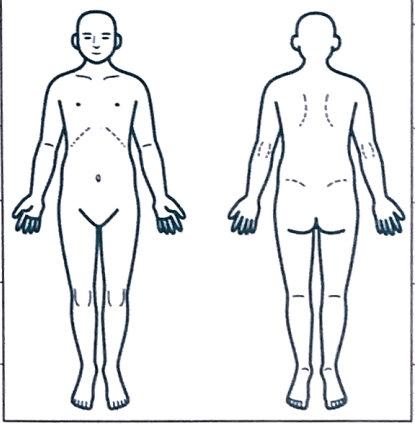
Are you also receiving care from any other health professionals? ○ Yes ○ No
- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Please indicate where you are experiencing pain or discomfort.
X= Current condition O= Past condition



Have you received care for this problem before? ○ Yes ○ No
- If yes, please explain:

When did the condition(s) first begin?

How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ○ Resolve existing condition(s) ○ Overall wellness ○ Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, what is their name?

What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutritional ○ Subluxation-based ○ Other: _____

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ○ Yes ○ No
- If yes, please explain:

Notable childhood injuries? ○ Yes ○ No If yes, please explain:

Youth or college sports? ○ Yes ○ No If yes, list major injuries:

Any auto accidents? ○ Yes ○ No If yes, please explain:

Exercise Frequency? ○ None ○ 1-3x per week ○ 4-6x per week ○ Daily
What types of exercise?

How do you normally sleep? ○ Back ○ Side ○ Stomach Do you wake up: ○ Refreshed and ready ○ Stiff and tired

Do you commute to work? ○ Yes ○ No If yes, how many minutes per day?

List any problems with flexibility. *(ex. Putting on shoes/socks, etc.)*

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Alcohol	①	②	③	④	⑤	Processed Foods	①	②	③	④	⑤
Water	①	②	③	④	⑤	Artificial Sweeteners	①	②	③	④	⑤
Sugar	①	②	③	④	⑤	Sugary Drinks	①	②	③	④	⑤
Dairy	①	②	③	④	⑤	Cigarettes	①	②	③	④	⑤
Gluten	①	②	③	④	⑤	Recreational Drugs	①	②	③	④	⑤

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None		*Moderate*		*High*		*None*		*Moderate*		*High*
Home	①	②	③	④	⑤	Money	①	②	③	④	⑤
Work	①	②	③	④	⑤	Health	①	②	③	④	⑤
Life	①	②	③	④	⑤	Family	①	②	③	④	⑤

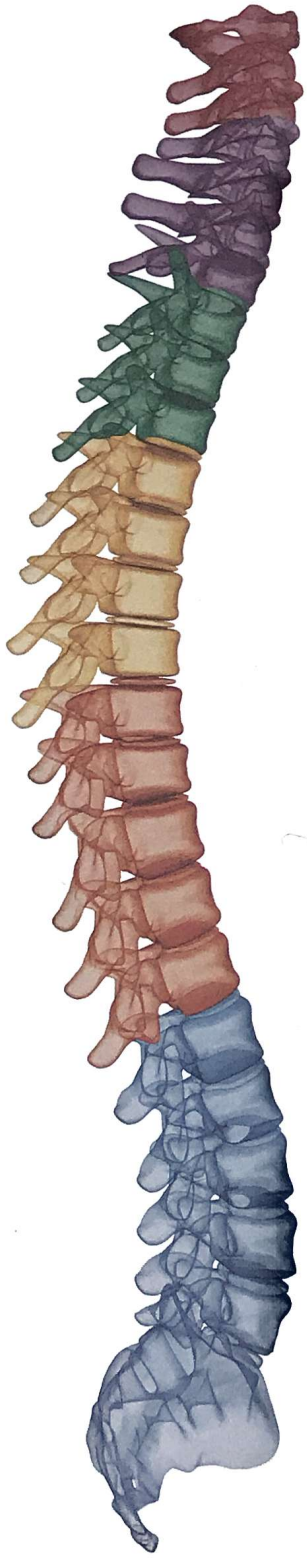
ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐	Colic & Excessive Crying	
		☐	☐	Ear & Sinus Infections	
		☐	☐	Allergies & Congestion	
		☐	☐	Immune Deficiency	
		☐	☐	Headaches & Migraines	
		☐	☐	Vertigo & Dizziness	
		☐	☐	Sore Throat & Strep	
		☐	☐	Swollen Tonsils & Adenoids	
		☐	☐	Vision & Hearing Issues	
		☐	☐	Low Energy & Fatigue	
		☐	☐	Difficulty Sleeping	
		☐	☐	Pain, Numbness & Tingling in Arms to Hands	
		☐	☐	Epilepsy & Seizures	
		☐	☐	Sensory & Spectrum	
		☐	☐	ADD / ADHD	
		☐	☐	Focus & Memory Issues	
		☐	☐	Anxiety & Stress	
		☐	☐	Balance & Coordination	
		☐	☐	Speech Issues	
		☐	☐	TMJ / Jaw Pain	
		☐	☐	Stiff Neck & Shoulders	
		☐	☐	Depression	
		☐	☐	High Blood Pressure	
		☐	☐	Poor Metabolism & Weight Control	
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐	Reflux / GERD	
		☐	☐	Chronic Colds & Cough	
		☐	☐	Asthma	
		☐	☐	Bronchitis & Pneumonia	
		☐	☐	Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐	Gallbladder Pain / Issues	
		☐	☐	Jaundice	
		☐	☐	Fever	
		☐	☐	Indigestion & Heartburn	
		☐	☐	Stomach Pains & Ulcers	
		☐	☐	Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐	Behavior Issues	
		☐	☐	Hyperactivity	
		☐	☐	Chronic Fatigue	
		☐	☐	Chronic Stress	
		☐	☐	Allergies & Eczema	
		☐	☐	Skin Conditions / Rash	
		☐	☐	Kidney Problems	
		☐	☐	Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐	Constipation	
		☐	☐	Crohn's, Colitis & IBS	
		☐	☐	Diarrhea	
		☐	☐	Bed-wetting	
		☐	☐	Bladder & Urination Issues	
		☐	☐	Cramps & Menstrual Issues	
		☐	☐	Cysts & Endometriosis	
		☐	☐	Infertility	
		☐	☐	Impotency	
		☐	☐	Hemorrhoids	
		☐	☐	Sciatica & Radiating Pain	
		☐	☐	Lumbopelvic / SI Joint Pain	
		☐	☐	Hamstring Tightness	
		☐	☐	Disc Degeneration	
		☐	☐	Leg Weakness & Cramps	
		☐	☐	Poor Circulation & Cold Feet	
		☐	☐	Knee, Ankle & Foot Pain	
		☐	☐	Weak Ankles & Arches	
		☐	☐	Lower Back Pain	
		☐	☐	Gluten & Casein Intolerance	

Patient Name: _____ Date: / /

BACK 2 BACK
CHIROPRACTIC
A Family Wellness Place

INFORMED CONSENT

Chiropractic is a non-surgical, non-invasive procedure and has one of the safest records in health care. As with any health care specialty, we cannot promise a cure, but we will give you the best care possible and discuss any questions or concerns with you.

Patients may experience temporary symptoms such as an increase in soreness following a massage, manipulation or traction. In addition, physiotherapy such as ice, heat, ultrasound or electrical muscle stimulation may irritate the skin. There have been rare cases where adjustments may have aggravated a bulging or herniated disc or caused a rib fracture. On extremely rare occasions, adjustments to certain areas of the cervical spine have been related to a compromise of the vertebral artery and possible stroke symptomatology. The most recent studies (Journal of the CAA, Vol. 37, No 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature_____ Date_____

Parent/Legal Guardian Signature_____ Date_____

BACK 2 BACK
CHIROPRACTIC
A Family Wellness Place

This is an agreement between Back 2 Back Chiropractic and the Patient names on this form. In this policy the words "you", "your", and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to Back 2 Back Chiropractic.

Insurance: We accept most insurance plans, but are only in network with Blue Cross Blue Shield. We are happy to verify your insurance benefits on your behalf. After verification, please contact your insurance company with further questions regarding coverage.

Proof of Insurance: We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance card prior to, or at the time of your first appointment you may have to self-pay for your appointment.

Coverage Changes: If your insurance changes it is your responsibility to inform us. Any fees acquired during this period of change not covered by your insurance are your responsibility.

Co-Payment, Deductible, Co-Insurance: It is your responsibility to pay any deductible, co-pay, co-insurance or any portion of the charge as specified by your plan. This is your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients is considered fraud. Please help us uphold the law by paying your portion of any charges at each visit.

Non-Covered Services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You agree to pay any portion of the charges that is not covered by insurance

Budget Plans: This office can set up a budget plan for any outstanding large balance; you will need to leave a credit card on file for our office to run on the specified date each month until your balance is paid off. Failure to abide by payment arrangement will result in the arrangement becoming null in void. If patient fails to make new payment arrangements further action will be taken up to, and including, sending account to collections.

Claim Submission: As a courtesy to you we will submit your claims and assist in any way we reasonably can to help get your claims paid. We will file to both your Primary and Secondary insurance policy only. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days, you are responsible for the remaining. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

BACK 2 BACK
CHIROPRACTIC
A Family Wellness Place

Equipment Loans: If necessary for your care, Dr. Wallin may prescribe at-home therapies that may require you to take a piece of therapy equipment home with you (i.e. ultrasound or e-stim). You will be required to check-out this equipment with the front desk. The equipment is due back on your next appointment unless otherwise stated at checkout. Equipment is due back within 45 days of checkout regardless of your next appointment date. Failure to return the equipment in a timely manner may result in a fee being charged to your account up to the cost of the equipment.

Missed Appointment/No-Show: Our policy is to charge for missed appointments. If you do not show up for an appointment, or do not cancel within 12 hours, there will be a missed appointment fee of $25.00. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. If you have to miss an appointment or reschedule for any reason please call and leave us a message or email us to avoid this fee.

Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

Please be aware that we will verify that you have active insurance and that we can file a claim on your behalf. We will verify specific covered services and codes. Please be aware that Back 2 Back Chiropractic is not responsible for any misinformation regarding insurance benefits. The information we receive is not a guarantee of payment as claims are subject to review based on the members plan.

Patient/Guardian: _____ **Patient DOB:** _____

Responsible Party (if not patient): _____ **Contact Phone #** _____

Signature: _____ **Date:** _____

B2B Staff Representative: _____ **Date:** _____