

**BackFit Chiropractic & Rehab.**

1949 W. Ray Rd., #14, Chandler, AZ 85224 Ph: 480-917-1720 F: 480-917-6934      754 S. Val Vista Dr., #105, Gilbert, AZ 85296 Ph: 480-497-2900 Fax: 480-497-2906  
 5233 E. Southern, #104, Mesa, AZ 85206 Ph: 480-830-2882 Fax: 480-830-2881      2824 E. Indian School Rd., Ste. 5, Phoenix, AZ 85016 Ph: 602-840-0056 F: 602-840-4056

Chandler Office    Gilbert Office    Mesa Office    Phoenix Office

**PATIENT APPLICATION FOR TREATMENT**

Today's Date: \_\_\_\_\_ Reason for this appointment: \_\_\_\_\_ How did you hear about us? : \_\_\_\_\_

Legal Name: \_\_\_\_\_ How would you like to be addressed? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: **M F** Marital Status: **S M D W**

SS#: \_\_\_\_\_ E-mail: \_\_\_\_\_ Home# \_\_\_\_\_ Cell # \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work#: \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_ Ph#: \_\_\_\_\_

Contact Address: \_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_ Ph#: \_\_\_\_\_

Contact Address: \_\_\_\_\_

Emergency Contact #3: \_\_\_\_\_ Ph#: \_\_\_\_\_

Contact Address: \_\_\_\_\_

Do you have insurance?  Yes  No Insurance Name: \_\_\_\_\_

Primary Insured?  Yes  No If no, Name of Primary & Relationship: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Have they or any members of your family received Chiropractic care?  Yes  No

Have you ever had Chiropractic Care?  Yes  No If yes, how long ago? \_\_\_\_\_

How often do you drink alcoholic beverages? \_\_\_\_\_ Do you smoke?  Yes  No How Much? \_\_\_\_\_

Do you exercise?  Yes  No How often? \_\_\_\_\_ Type? \_\_\_\_\_ Do you have any allergies? (Specify): \_\_\_\_\_

**Have you ever suffered from or been diagnosed as having** :( Circle Yes or No for each)

- |                                |                        |                          |               |
|--------------------------------|------------------------|--------------------------|---------------|
| Y N *Broken or Fractured Bones | Y N Excessive Bleeding | Y N Seizures/Convulsions | Y N Ulcers    |
| Y N *Osteoarthritis            | Y N Congenital Disease | Y N Pacemaker            | Y N Strokes   |
| Y N Eating Disorder            | Y N Ruptures           | Y N Drug Addiction       | Y N Tumors    |
| Y N Circulatory Problems       | Y N Gall Bladder       | Y N Alcoholism           | Y N Epilepsy  |
| Y N *Rheumatoid Arthritis      | Y N HIV Positive       | Y N Coughing Blood       | Y N *Diabetes |
| Y N High/Low Blood Pressure    | Y N Depression         | Y N *Head Problems       | Y N *Cancer   |

\*Explanation: \_\_\_\_\_

When was your last physical Examination? \_\_\_\_\_

When was the last time you were involved in an accident of any kind? \_\_\_\_\_

**Primary Care Physician:**

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Medication List:**

Names of Medications	Names of Vitamins	Non-RX Strength	RX Strength	Date Started	Date Stopped	Who Prescribed	
						Dr.	Self

Dr. Initials: \_\_\_\_\_



# BACKFIT CHIROPRACTIC AND REHAB

Chandler Gilbert Mesa Phoenix

Dr's Initials: \_\_\_\_\_

## PATIENT HISTORY

Chief Complaint : \_\_\_\_\_ When did it start? \_\_\_\_\_

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Mild

Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100
----	----	----	----	----	----	----	----	----	-----

Has the pain ever been a level 9 or 10?  Yes  No

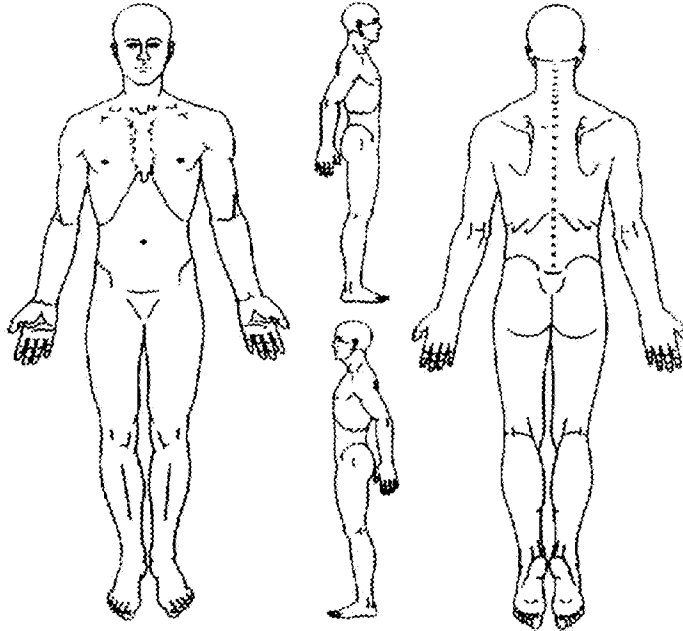
When do you feel it most?  AM  PM When present, how long does the complaint last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs

What makes it feel better? \_\_\_\_\_ What makes it feel worse? \_\_\_\_\_

Note: If you need additional sheets, please ask the front desk.

Using the letters below, please show **where** you are experiencing **all** of your current complaints:

- A: Ache
- B: Burning
- C: Cramping
- D: Dull Pain
- F: Stiffness
- N: Numbness
- R: Throbbing
- S: Soreness
- T: Tingling
- X: Sharp Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

- Walking Y N
- Standing Y N
- Running Y N
- Sleeping Y N
- Driving Y N
- Personal Grooming Y N
- Sitting Y N
- Kneeling Y N
- Exercising Y N
- Bending Y N
- Lifting Objects Y N
- Lifting Children Y N
- Housework Y N

- Have you ever had the condition(s) in the past?  Yes  No If yes, please indicate what sort of treatment have you ever had:  Hospitalization  Chiropractic care  Medical doctor / Specialty provider  None
- Have you ever lost work due to your condition(s)?  Yes  No If Yes, dates? \_\_\_\_\_
- Are you pregnant?  Yes  No Number of pregnancies? \_\_\_\_\_ Number of miscarriages? \_\_\_\_\_
- What was the first day of your last menstrual cycle? \_\_\_\_\_

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low			Medium				High			
0	1	2	3	4	5	6	7	8	9	10

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge:

Patient Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

1949 W. Ray Rd., #14, Chandler, AZ 85224 Ph: 480-917-1720 F: 480-917-6934 754 S. Val Vista Dr., #105, Gilbert, AZ 85296 Ph: 480-497-2900 Fax: 480-497-2906

5233 E. Southern, #104, Mesa, AZ 85206 Ph: 480-830-2882 Fax: 480-830-2881 2824 E. Indian School Rd., Ste. 5, Phoenix, AZ 85016 Ph: 602-840-0056 F: 602-840-4056