

Back In Action Chiropractic
11830-C Canon Blvd, Newport News, VA 23606
(757) 873-7786

Initial Case History

Name				Date
Address				
City		State	Zip	Birthday
Age	Sex	Marital Status		SS#
Phone		Work/Cell/Pager		
Email		Employer		
Occupation		Number of Years		
Spouse: Name		SS#	Birthday	
How were you referred to our office?				

Reason for today's visit:

When did this happen?	How did it start?
Have you had this condition before? If yes, when?	
Did you have an accident?	Auto Work Fall Other
What makes it worse?	
What makes it feel better?	
Have you seen any other healthcare providers for this condition?	
If yes, who and what testing was done?	
Please list ALL medications, herbs and nutritional supplements you are currently taking:	

Do you have any other health conditions, illnesses, issues, surgeries, injuries?

Have you seen a chiropractor before? If yes, who & when?	
Family physician	Last office visit
Have you ever been hospitalized? If yes, describe.	

List any allergies.	
Women Only: Are you currently pregnant?	Date of last period
How much do you...? Exercise weekly	Smoke Daily
Caffeinated Beverages daily	Alcoholic beverages/recreational drugs weekly

Insurance Information

Do you have health insurance that will cover any portion of your chiropractic care?	
Insurance Company	Name on Policy
If this is someone other than you: relationship	their birthday

Please give you insurance card, id and any necessary forms to the receptionist.

By my signature, I understand and agree that any information stated herein is accurate and truthful to the best of my knowledge. I also understand and agree that any insurance policies are an agreement between the carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount paid directly to this office will be credited to my account upon receipt. However, **I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that all co-pays, deductibles and cash services are due in full at the time of service.** I also understand that if I suspend or terminate my care and treatment, my account balance will be due in full immediately. Any financial arrangements made on my account will become null and void at termination of care or noncompliance of treatment recommendations. I give this office permission to release any appropriate information, including medical records, to my insurance company so that my claims may be processed. By filling out these forms, I am authorizing the chiropractor to examine me.

Signature: _____ Date: _____

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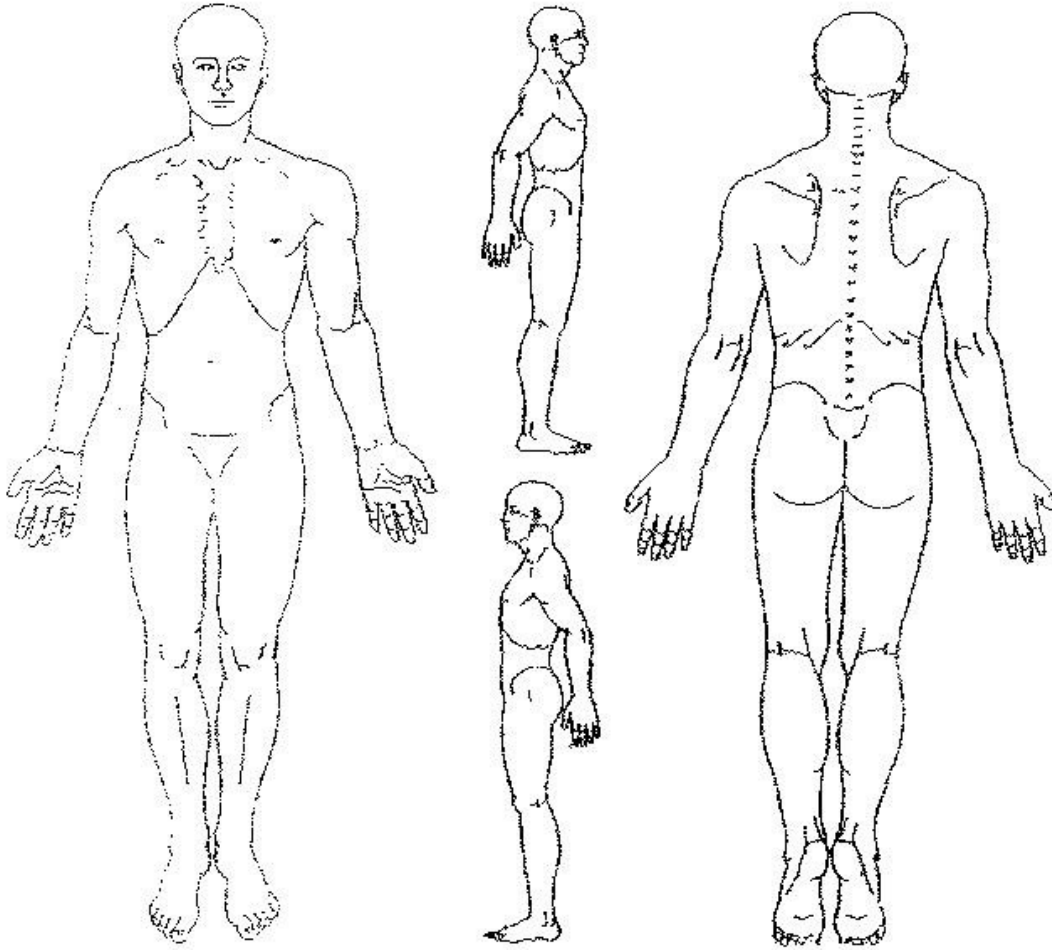
Name _____ Date: _____

Age _____ Birthday: _____ Occupation: _____

Is this your first episode of pain like you have described? _____ Yes _____ No

Use the letters below to indicate the type and locations
Of your sensations right now

A= Ache B= Burning N= Numbness M= Muscle soreness
S= Stiffness P= Pins & Needles K= Stabbing O= Other



GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain **presently** prevents you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst.

Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. FAMILY / AT-HOME RESPONSIBILITIES SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

2. RECREATION INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

3. SOCIAL ACTIVITIES INCLUDING PARTIES, THEATER, CONCERTS, DINING -OUT AND ATTENDING OTHER SOCIAL FUNCTIONS -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

4. EMPLOYMENT INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

5. SELF-CARE SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSES -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

6. LIFE-SUPPORT ACTIVITIES SUCH AS EATING AND SLEEPING -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____

DATE _____

SCORE _____ / 60

BENCHMARK -> 5 _____