



Our mission is to educate and adjust as many people as possible toward optimal health using natural chiropractic care.

CONFIDENTIAL PATIENT INFORMATION:

Today's Date: _____

Name: _____

Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Age: _____ Male Female

Marital Status: Married Single Divorced Separated Other _____

Name of Spouse/Nearest Relative: _____ Phone: _____

Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____

Yellow Pages Mail Clinic Location Other _____

Payment for Services will be: Cash Check Automobile Insurance Worker's Compensation
 Health Insurance

Name of Insurance Co.: _____

Insured's Employer: _____

Insured's Social Security #: _____

Are you covered by more than one insurance company? Yes No

If Yes, Name of other insurance company _____

ACCIDENT HISTORY:

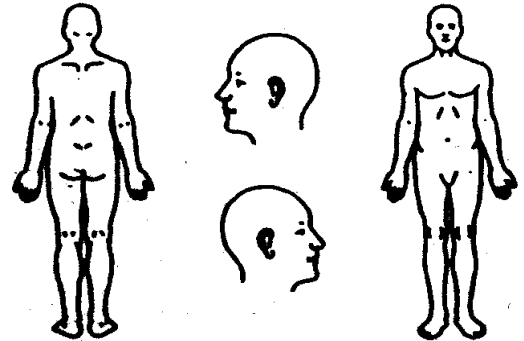
Job Auto Other 1 _____ Date: _____
 Job Auto Other 2. _____ Date: _____
 Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Circle areas of complaint below

PLEASE RATE YOUR SYMPTOMS (1-10, 1 being the least serious)

	DESCRIPTION	RATING
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____



SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT OTHER
 ACCIDENT ILLNESS UNKNOWN CAUSE GRADUAL ONSET

DATE OCCURRED: _____

SYMPTOMS HAVE LASTED ___ HOUR(S) ___ DAY(S) ___ WEEK(S) ___ MONTH(S) ___ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD _____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION: BENDING
 REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD LIFTING SNEEZING
 WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION: BENDING
 SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING: blurred vision
 buzzing in ears cold feet cold hands cold sweats concentration loss/confusion
 constipation depression/weeping spells diarrhea dizziness face flushed fainting fatigue
 fever head seems too heavy headaches insomnia light bothers eyes loss of balance loss
of smell loss of taste low resistance to colds muscle jerking numbness in fingers numbness
in toes pins and needles in arms pins and needles in legs ringing in ears shortness of breath
 stiff neck stomach upset

OTHER DOCTORS SEEN RECENTLY: _____ FOR: _____

Back on Track Chiropractic--2051 W. Warner Rd. #1 Chandler, AZ 85224 Phone: 480-963-0504 fax:480-963-2899

MEDICATIONS: _____
SURGERIES/HOSPITALIZATIONS: _____

MAJOR ILLNESSES YOU HAVE HAD: _____

MAJOR ILLNESS IN YOUR FAMILY: _____

WHAT ARE YOUR HEALTH CARE GOALS?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHAT ARE YOUR FAVORITE HOBBIES OR ACTIVITIES _____

ARE YOUR CURRENT PROBLEMS AFFECTING THESE HOBBIES OR ACTIVITIES? NO YES

ON A SCALE OF 1-10 (1 being the least, 10 being the most)

_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your health potential?

There is no charge for today's consultation. Should you elect to receive care in this office, the initial exam fee is \$155 plus any X-Rays needed for your case.

DISCLAIMER:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. I, also authorize the release of any health information necessary to process this claim. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I authorize the use of this signature on all insurance submissions.

Patient's Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____



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(480)963-0504

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same goal.

The doctors at Back On Track Chiropractic are concerned with the detection and correction of subluxations (nerve interference). Her/his goal is to locate, analyze and correct these subluxations for the purpose of allowing the proper transmission of nerve energy over the nerve pathways. This allows the innate healing ability of the body to work at the maximum efficiency. With subluxations reduced, the body can begin the process of repair leading to health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

The primary method for removing subluxations is manual adjustments to the joints of the body. There are times when the adjustment is supplemented with other methods such as traction, exercise, hot or cold packs, or other non-invasive modalities which your doctor considers necessary. These modalities are used in order to properly correct subluxations, or help the patient hold adjustments. In addition, nutritional supplements, orthotics or lifestyle counseling may be included if it is specifically for the purpose of helping the patient to be subluxation-free.

We do not diagnose diseases nor claim to cure disease. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care.

Signature

Date

Complete below if patient is a minor child.

Print Child's Name

I, _____ being the parent or legal guardian of the aforementioned

Print Parent or Guardian's Name

child, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of Parent or Guardian

Date