

# BACK TO HEALTH

## CHIROPRACTIC

25 W. Lincoln Ave. Charleston, IL 61920 (217) 345.9600 FAX (217) 345.3045

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### WELCOME TO OUR OFFICE

In compliance with Federal and State Consumer Protection and Informed Consent Laws, we present the following basic outline of usual and customary procedures and fees.

**OFFICE FINANCIAL POLICY:** Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under care.

If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your budget.

If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once a month or longer, you will not be eligible for Insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

For your convenience, you may retain your credit card number on file with us.

Card # \_\_\_\_\_  
Expiration Date \_\_\_\_\_ Name as it appears on card: \_\_\_\_\_

**Treatment Permission:** I give permission to Dr. Schuster to administer treatment and perform such general procedures, as he deems necessary in the diagnosis and treatment of my condition. Any risk regarding care will be explained to me upon my request.

**Payment Responsibilities:** I understand that I am personally responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Coles County and that if I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. I agree to pay all reasonable costs incurred to collect the debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency fees or contingencies, service fees, and other related collection costs or contingencies. This provision also shall apply if I file a petition or any other claim for relief under any bankruptcy rule of law of the United States, or if another files such petition or other claim for relief against me. All portions of any bill sent me by Back to Health Physician's Group, LTD shall be assumed valid unless disputed in writing within 30 days of receiving the bill.

**Assignment of Right to Payment/Lien Against Benefits:** I hereby authorize Back to Health Physician's Group, LTD to file my claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Back to Health Physicians Group, LTD. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements, or recoveries, and to adequately protect and to make payment for these services directly to Back to Health Physician's Group, LTD pursuant to this assignment and lien.

**Assignment of Cause of Action:** In the event that any insurance company or other third party that may be obligated to make payment to me or to Back to Health Physicians Group, LTD, for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer, and convey to Back to Health Physicians Group, LTD, the cause of action that might exist in my favor against any such company or person. I authorize Back to Health Physicians Group, LTD, to prosecute said action either in my name or their name to collect fees due for care rendered at Back to Health Physicians Group, LTD, and legal expenses and to resolve said claims as they see fit.

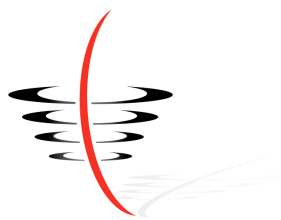
**Authorization to Process Draft:** I agree that Back to Health Physicians Group, LTD, shall be appointed as my agent to endorse drafts or sign my name on checks for payment of my bill for services rendered.

**Limited Release of Medical Information:** I authorize Back to Health Physicians Group, LTD, to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

This is NOT a consumer credit transaction. Dr. Schuster is DBA/Back to Health Physicians Group.

Witness: \_\_\_\_\_ DATE: \_\_\_\_\_



**BACK TO HEALTH**  
CHIROPRACTIC

**RECORD RELEASE AUTHORIZATION**

**DOCTOR/HOSPITAL:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:**

**THANK YOU IN ADVANCE FOR YOUR COOPERATION.**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient's Name (Please Print)**

\_\_\_\_\_  
**Parent/Guardian Signature (If patient under 18 yrs old)**

\_\_\_\_\_  
**Relationship To Patient**

\_\_\_\_\_  
**Witness To The Above Signatures**

\_\_\_\_\_  
**Please Print Name**

## NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and Preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you by mail, email or telephone for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Patient Signature \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

The effective date of this Notice of Information Practices is \_\_\_\_\_

## INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

The goals of the rehabilitation program include:

1. Determining the cause and extent of your problem.
2. Providing therapeutic exercise programs, and/or soft tissue mobilization, to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

### **ALL EQUIPMENT AND TESTS WILL BE THOROUGHLY EXPLAINED TO YOU PRIOR TO USE.**

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and Employer, if it is applicable.

Back To Health Physician's Group LTD is providing a course of treatment called S.A.S.T.M. (sound assisted soft tissue mobilization). Participation in this course of treatment may or may not benefit you. Benefits of participation may include improvement of your biomechanics.

There are also risks inherent in any athletic activity. These risks include muscle, joint, or ligament injury; falls which could lead to fracture bruising, cuts, or eye injuries; overuse injuries such as stress fractures, increased blood pressure, fainting, disorder of heartbeat, and in rare instances, heart attack or stroke which could result in death.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified.

Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider.

**In consideration of permitting me to participate in this evaluation & rehabilitation program, and in full recognition and appreciation of the dangers inherent in this course of treatment to which I may be exposed during my participation, I agree to assume all of the risk and responsibility surrounding my participation in said program. I do for myself, my heirs, and my personal representatives hereby hold harmless, indemnity, release, and forever discharge Back To Health Physician's Group LTD, and all of it's directors, officers, agents, and employees from and against any and all claims, demands and actions, or causes of action, on participation and which results from causes beyond the control of and without the fault of negligence of Back To Health Physician's Group LTD, it's directors, officers, agents, or employees during my participation in this course of treatment.**

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand the neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment, based upon facts known, that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which include rarely, but not limited to, fractures, disc injuries, strokes, and strains/sprains and therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have has an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

### Female patients ONLY:

**By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.**

**Date of last menstruation:**

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or authority if not signed by patient

\_\_\_\_\_  
Witness (Print)

\_\_\_\_\_  
Witness Signature

# Patient Basic Information

## Personal Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Injury/Onset: \_\_\_\_\_ Other Doctor(s) that has Treated this Condition: \_\_\_\_\_ When: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_

## Insurance Information:

Policy Holder (if different than patient): \_\_\_\_\_ Policy No.: \_\_\_\_\_

How did you hear About Us? \_\_\_\_\_

Dominant Hand: Right Left Both

## Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

**I. Current Symptom:** (Please check off the boxes below to describe your symptom. Please check all of your current symptoms.)

<input type="checkbox"/> Headaches	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Front of head			
<input type="checkbox"/> Top of head			
<input type="checkbox"/> Back of head			
<input type="checkbox"/> Jaw	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Eye	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Neck	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Upper Back	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Mid Back	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Low Back	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Chest	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Abdomen	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Ribs	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Buttocks	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Forearm	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hand	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hip	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Leg	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Foot	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
Other: _____			

**3. Pain Frequency**

Up to 1/4 of time 1/4 to 1/2 of time

1/2 to 3/4 of time Most of the time

**4. Pain Intensity (how affects daily living)**

Doesn't Somewhat

Seriously Completely

**5. Does the pain radiate into other body parts?**

<input type="checkbox"/> Head	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Neck	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Arm	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hand	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hip	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Leg	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Foot	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
Other _____			

**6. Actions affecting this pain**

	Brings it on	Aggravates it	Relieves it
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Fwd.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. Types of Pain**

Dull Sharp Aching Cutting

Throb Burn Numb Tingling

Cramp Spasm Stinging Shooting

Pounding Constricting

Other \_\_\_\_\_

**Other Comments:**

\_\_\_\_\_

\_\_\_\_\_

# Activities of Daily Living Assessment (Only fill in areas affected)

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

**1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain".

## Difficulties with Self Care and Personal Hygiene Activities

Bathing\_\_\_\_ Drying hair\_\_\_\_ Brushing teeth\_\_\_\_ Putting on shoes\_\_\_\_ Preparing meals\_\_\_\_ Taking out trash\_\_\_\_ Showering\_\_\_\_  
Combing hair\_\_\_\_ Making bed\_\_\_\_ Tying shoes\_\_\_\_ Eating\_\_\_\_ Doing laundry\_\_\_\_ Washing hair\_\_\_\_ Washing face\_\_\_\_  
Putting on shirt\_\_\_\_ Putting on pants\_\_\_\_ Cleaning dishes\_\_\_\_ Going to toilet\_\_\_\_

## Difficulties with Physical Activities

Standing\_\_\_\_ Walking\_\_\_\_ Kneeling\_\_\_\_ Bending back\_\_\_\_ Twisting left\_\_\_\_ Leaning back\_\_\_\_ Sitting\_\_\_\_ Stooping\_\_\_\_  
Reaching\_\_\_\_ Bending left\_\_\_\_ Twisting right\_\_\_\_ Leaning left\_\_\_\_ Reclining\_\_\_\_ Squatting\_\_\_\_ Bending forward\_\_\_\_  
Bending right\_\_\_\_ Leaning forward\_\_\_\_ Leaning right\_\_\_\_ Standing for long periods\_\_\_\_ Sitting for long periods\_\_\_\_  
Walking for long periods\_\_\_\_ Kneeling for long periods\_\_\_\_

## Difficulties with Functional Activities

Carrying small objects\_\_\_\_ Lifting weights off floor\_\_\_\_ Pushing things while seated\_\_\_\_ Exercising upper body\_\_\_\_  
Carrying large objects\_\_\_\_ Lifting weights off table\_\_\_\_ Pushing things while standing\_\_\_\_ Exercising lower body\_\_\_\_  
Carrying brief case\_\_\_\_ Climbing stairs\_\_\_\_ Pulling things while seated\_\_\_\_ Exercising arms\_\_\_\_  
Carrying large purse\_\_\_\_ Climbing inclines\_\_\_\_ Pulling things while standing\_\_\_\_ Exercising legs\_\_\_\_

## Difficulties with Social and Recreational Activities

Bowling\_\_\_\_ Jogging\_\_\_\_ Swimming\_\_\_\_ Ice Skating\_\_\_\_ Competitive Sports\_\_\_\_ Dating\_\_\_\_ Golfing\_\_\_\_ Dancing\_\_\_\_  
Skiing\_\_\_\_ Roller Skating\_\_\_\_ Hobbies\_\_\_\_ Dining out\_\_\_\_

## Difficulties with Traveling

Driving a motor vehicle\_\_\_\_ Riding as a passenger in a motor vehicle\_\_\_\_ Riding as a passenger on a train\_\_\_\_  
Driving for long periods of time\_\_\_\_ Riding as a passenger on an airplane\_\_\_\_ Riding as a passenger for long periods\_\_\_\_

Use the following 1 to 5 scale to describe the difficulties below:

**1** = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

## Difficulties with Different Forms of Communication

Concentrating\_\_\_\_ Hearing\_\_\_\_ Listening\_\_\_\_ Speaking\_\_\_\_ Reading\_\_\_\_ Writing\_\_\_\_ Using a keyboard\_\_\_\_

## Difficulties with the Senses

Seeing\_\_\_\_ Hearing\_\_\_\_ Sense of touch\_\_\_\_ Sense of taste\_\_\_\_ Sense of smell\_\_\_\_

## Difficulties with Hand Functions

Grasping\_\_\_\_ Holding\_\_\_\_ Pinching\_\_\_\_ Percussive movements\_\_\_\_ Sensory discrimination\_\_\_\_

## Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep\_\_\_\_ Being able to participate in desired sexual activity\_\_\_\_

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

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## Prior Symptom History

### Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
- My current complaints DID exist before, but had not been bothering me.
- My current complaints ALREADY existed and were worsened.

### Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
- My history HAS NOT contributed to my current symptoms.
- I'm NOT SURE if my history has contributed to my current Symptoms.

My most recent prior similar symptoms (if applicable) occurred: \_\_\_\_\_  months ago /  years ago **OR on Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Write in below any other Prior Symptom History, not covered above:

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**FAMILY HISTORY** List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

**SOCIAL HISTORY** Circle the dot and fill in.

Current Weight \_\_\_\_\_ Have you recently lost or gained weight? \_\_\_\_\_

Mental Work: • Heavy • Moderate • Light Hours per day \_\_\_\_\_

Physical Work: • Heavy • Moderate • Light Hours per day \_\_\_\_\_

Exercise: • Heavy • Moderate • Light Hours per week \_\_\_\_\_

Smoking: • Current Packs/Day \_\_\_\_\_ • Previous No. of years \_\_\_\_\_

Alcohol: Beer/Week \_\_\_\_\_ Liquor/Week \_\_\_\_\_

Wine/Week \_\_\_\_\_ No. of Years \_\_\_\_\_

Caffeine: (Coffee, Tea, Cola) Cups/Day \_\_\_\_\_ No. of Years \_\_\_\_\_

Aspirin: No./Day \_\_\_\_\_ No. of Years \_\_\_\_\_ Others \_\_\_\_\_

**MARK THE AREAS OF YOUR SYMPTOMS** See the figure to below, Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles .... Stabbing ////

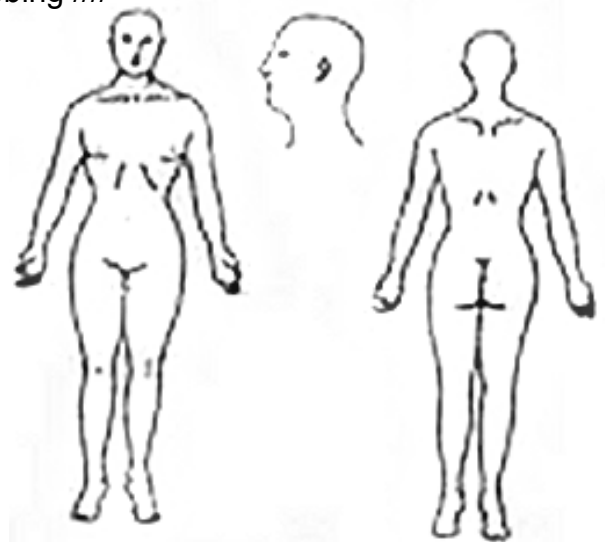
**MARK AN "X" ON THE LINES:**

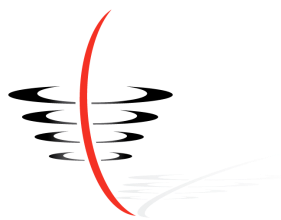
How bad are your symptoms now?

\_\_\_\_\_ None \_\_\_\_\_ Most Severe

How bad have they been in the past?

\_\_\_\_\_ None \_\_\_\_\_ Most Severe





# BACK TO HEALTH

## CHIROPRACTIC

Name \_\_\_\_\_ Date \_\_\_\_\_

What prescription medications and supplements are you taking? Please list here -

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### Sleep

Do you have trouble falling asleep? \_\_\_ Yes \_\_\_ No Do you have trouble Staying Asleep? \_\_\_ Yes \_\_\_ No

What over the counter or prescription medications have you taken for sleep?

\_\_\_ Ambien \_\_\_ Zanaflex \_\_\_ Trazadone \_\_\_ Sonata \_\_\_ Tylenol P.M. \_\_\_ Elavil \_\_\_ Neurontin \_\_\_ Doxepin \_\_\_ Flexeril \_\_\_ Xanax  
\_\_\_ Klonopin \_\_\_ Ativan \_\_\_ Melatonin \_\_\_ 5HTP \_\_\_ Benadryl \_\_\_ Other

### Digestion and Elimination

Do you have normal, daily bowel movements (at least one bowel movement a day)? \_\_\_ Yes \_\_\_ No

If no, please circle one - diarrhea, constipation, or both?

Have you been diagnosed with Irritable Bowel Syndrome (IBS)? \_\_\_ Yes \_\_\_ No

Bloating \_\_\_ Yes \_\_\_ No Gas \_\_\_ Yes \_\_\_ No Indigestion \_\_\_ Yes \_\_\_ No \_\_\_ Reflux?

### Intestinal Dysbiosis

Have you ever been on long-term (more than 2 weeks) antibiotic therapy? \_\_\_ Yes \_\_\_ No

Have you ever had vaginal yeast infections? \_\_\_ Yes \_\_\_ No

If yes, when was last infection? \_\_\_\_\_

Do you have chronic vaginal yeast infections (more than 2 a year)? \_\_\_ Yes \_\_\_ No

Have you taken birth control pills for more than 1 year? \_\_\_ Yes \_\_\_ No

Do you crave Sugar? \_\_\_ Yes \_\_\_ No

Does eating sugar make your symptoms worse? \_\_\_ Yes \_\_\_ No

Do you have rectal itching after eating sugar, fruit, or a lot of starches? \_\_\_ Yes \_\_\_ No

Have you EVER been on prednisone or cortisone long-term (weeks)? \_\_\_ Yes \_\_\_ No

Have you EVER been on long term (month or more) non-steroidal anti-inflammatory medications (Vioxx, Celebrex, Naprosyn, Advil, Bextra, Mobic, etc.)? \_\_\_ Yes \_\_\_ No

### Thyroid

Please check any of the following that apply-

\_\_\_ Fatigue \_\_\_ High Cholesterol \_\_\_ Chronic Headaches \_\_\_ Cold hands/feet \_\_\_ Hair loss \_\_\_ Irregular periods

\_\_\_ Severe menstrual cramps \_\_\_ Low blood pressure

\_\_\_ Frequent colds and sore throats \_\_\_ Depression \_\_\_ Fluid retention \_\_\_ Decreased memory \_\_\_ Ringing in the ears

\_\_\_ Decreased concentration \_\_\_ Infertility \_\_\_ Decreased sex drive \_\_\_ Constipation \_\_\_ Inappropriate weight gain

### Moods

Have you taken any anti-depressants in the past? \_\_\_ Yes \_\_\_ No

Are you currently taking any antidepressants? \_\_\_ Yes \_\_\_ No Do you feel \_\_\_ Depressed \_\_\_ Anxious?

Please list here \_\_\_\_\_

### Immune Function Please check those that apply.

\_\_\_ Chronic Sinus Congestion \_\_\_ Chronic Sinus Infections (2 or more a year) \_\_\_ Chronic Sore Throats \_\_\_ Chronic Colds or Flu infections each year \_\_\_ Chronic Upper Respiratory Infections (Bronchitis, Pneumonia)

**Adrenal Function**

If you skip a meal do you feel bad (have headaches, become irritable, get jittery, tired, etc.)?  Yes  No  
Do you have low blood pressure?  Yes  No  Don't Know  
Do you crave salty foods?  Yes  No  
Does increased stress or stressful situations make your symptoms worse?  Yes  No  
How's your energy level? Choose 1 to 5, with 5 being the best. \_\_\_\_\_  
How is your concentration and memory on a scale of 1-5, with 5 being best? \_\_\_\_\_  
How do you feel in the morning?  Refreshed  Hung over  Exhausted  
 Nauseated  Achy All Over  
Are you hungry in the morning?  Yes  No

**Please place a check mark by any that apply below**

Do you ever have problems with:

**Chemical Sensitivities/ Seasonal Allergies:**  Yes  No

**CVS:**

Chest Pain  Palpitations  High Cholesterol  High Blood Pressure  MVP  Congestive Heart Failure  
 Type I or II diabetes  Strokes

**Lungs:**

Coughing  Wheezing  Breathing Problems  Frequent Respiratory Infections  Sinus infections  
 Frequent sinus congestion or drainage

**GU:**

Urinary Frequency  Urinary Hesitancy

**Male:**

Problems with Prostrate (BPH)  Low sex drive  Erectile dysfunction

**Female:**

Irregular Periods  Heavy periods  Bloating/swelling  Cramps  Mood changes  
 Decreased Sex Drive  Menopause  Perimenopause

**Skin:**

Rashes  Dry Skin  Fungus Infections  Eczema  Psoriasis

**Pain:**

Do you have Osteoarthritis  Yes  No  
If so where (knees, fingers, back, etc.) \_\_\_\_\_

Rheumatoid or autoimmune arthritis  Yes  No  
If so where \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date