Back Pain Relief Chiropractic, P.C.

Dr. Thomas M. Andrews, D.C.

1108 S. 13th Street, Artesia, NM 88210

BPRC Confidential Patient Information Form, page 1 of 2

Name: ____ Date: ________________

Mailing Address: ________________________ City: _____________ State: _____ Zip: ______

SS#:________________________________ Date of Birth:___________________ Age: _____

Best # to reach you: Home: ____________ Work: _____________ Cell : __________________

E-mail Address:____

Employer: ____

Are you a student? _______ Full Time: _____ Part Time: _____ Where?: __________________

Single: _____ Widowed: _____ Married: _______ Spouse's Name: ______________________

When was your last visit to a chiropractor? ________________Who?: ______________________

How did you hear about our office? ____

Please list the name of someone that we may contact in case of an emergency:

Name: _________________________________ Phone Number: _______________________

PAST HEALTH HISTORY

List any hospitalizations, surgeries, motor vehicle accidents, major traumas, or ER visits:

____

____

List all health conditions that you have been or are now being treated for:

____

____

List any/all medications, including vitamins, you are now taking:

____

____

FAMILY HEALTH HISTORY

List any and all Health concerns that your immediate Family Members are experiencing or have experienced. If immediate family members have passed, list age and cause of death.

____

____

SOCIAL HISTORY

If you use tobaccos products or alcohol, list amounts and frequency here: ______________________

BPRC Confidential Patient Information Form, page 2 of 2

YOUR CURRENT CHIEF COMPLAINT AND HEALTH HISTORY

If you have more than one complaint, complete the next page. Use one section for each complaint.

Height: ____________________ Weight: ___________________ Are you Pregnant? ______________

What is your **CHIEF / MAIN** complaint? ____

How long have you had this condition? ____

Is this the FIRST time you have had this condition? _________________If No, last episode: __________

What caused this to occur? ____

Does the pain radiate to any other part of your body? ____

On a scale of 1-10 how would you rate the intensity of your pain? _________________________________

Quality of Pain / Symptom: (circle those that apply): Sharp Stabbing Dull Ache Throbbing Numb

Other: ___________________________________

When you are awake, how often is the pain present?: 0-25% of time 26-50% 51-75% Constant

Does anything give you relief from your pain? ____

Does anything aggravate the pain? ____

Do you feel better during certain times of the day? ____

Since the pain/symptom began; has it been getting better, staying the same, or getting worse? _________

Have you ever been treated by ANY other doctor for this condition? ______________________________

If yes, by whom? ____________________________How long ago? _________________________

What were the results? ____

Patient Signature: ____ Date: __________________

MEDICAL DOCTOR REFERRAL

If you were referred to our office by another Doctor, who?: ______________________________________

ACCIDENT INFORMATION

Are you seeking care due to an:

1. Injury on the job? Yes___ No____
2. Auto Accident? Yes____ No____
3. Other type of accident? Yes____ No____

If yes to any of the above, date of injury: ________

INSURANCE DATA

Policyholder Name: __________________________________ SS#: _____-___-_____ DOB: ___________

I understand that although I have assigned insurance benefits to this office it is likely and probable that my insurance coverage will be less than the amount billed. I acknowledge that it is my responsibility to pay the balance of my bill once the insurance benefits have been received.

Patient Signature: ____ Date: __________________

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ADDITIONAL CURRENT COMPLAINTS AND HEALTH HISTORY

Name: ____ Date: ___________________

Please describe your health issue: ____

How long have you had this condition? ____

Is this the FIRST time you have had this condition? ________________If No, last episode: ___________

What caused this to occur? ____

Does the pain radiate to any other part of your body? ____

On a scale of 1-10 how would you rate the intensity of your pain? ______________________________

Quality of Pain / Symptom: (circle those that apply): Sharp Stabbing Dull Ache Throbbing ________

When you are awake, how often is the pain present? 0-25% of time 26-50% 51-75% Constant

Does anything give you relief from your pain? ____

Does anything aggravate the pain? ____

Do you feel better during certain times of the day? ____

Since the pain/symptom began; has it been getting better, staying the same, or getting worse? _________

Have you ever been treated by ANY other doctor for this condition? _____________________________

If yes, by whom?: ___________________________How long ago?: _______________________

What were the results? ____

Patient Signature: ____ Date: _________________

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Please describe your health issue: ____

How long have you had this condition? ____

Is this the FIRST time you have had this condition? ________________If No, last episode: ___________

What caused this to occur? ____

Does the pain radiate to any other part of your body? ____

On a scale of 1-10 how would you rate the intensity of your pain? ______________________________

Quality of Pain / Symptom: (circle those that apply): Sharp Stabbing Dull Ache Throbbing ________

When you are awake, how often is the pain present?: 0-25% of time 26-50% 51-75% Constant

Does anything give you relief from your pain? ____

Does anything aggravate the pain? ____

Do you feel better during certain times of the day? ____

Since the pain/symptom began; has it been getting better, staying the same, or getting worse? _________

Have you ever been treated by ANY other doctor for this condition? _____________________________

If yes, by whom?: ___________________________How long ago?: _______________________

What were the results? ____

Patient Signature: ____ Date: _________________