Back Pain Relief Chiropractic, P.C.

Dr. Thomas M. Andrews, D.C.

1108 S. 13th Street, Artesia, NM 88210

BPRC Confidential Patient Information Form

Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Best # to reach you: Home: _____ Work: _____ Cell : _____

E-mail Address:_____

Employer: _____

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: _____

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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BPRC Confidential Patient History Form

Name: _____

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 of passing and cause of death.

_____
_____

PERSONAL 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:

_____
_____

SOCIAL HISTORY

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

_____

AREAS OF YOUR DAILY LIFE THAT ARE AFFECTED BY THIS CONDITION

	UNABLE TO PERFORM	DIFFICULTY	NO ISSUES
SELF CARE (get dressed, comb hair, etc)	_____	____	____
WORK	_____	____	____
RECREATION (golf, sports, hobbies)	_____	____	____

Patient Signature: _____ Date: _____

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YOUR CURRENT CHIEF COMPLAINT = "What is the # 1 reason we are seeing you today?"

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

ONE sheet Per Issue. Example: Neck Pain is one sheet, Low Back would be another sheet, etc.

Thank you for being thorough; it helps us help you. NOTE: If you have low back pain that goes into your mid back, hip or leg one sheet is OK. Or if you have neck pain that runs up into the back of your head or into your shoulder, etc. you can just use one sheet.

Patient Name _____

What is your **CHIEF / MAIN** health issue? _____

Is this a Flare Up of something you have had before, or is it a New Condition? _____

How long has this been bothering you? _____

What caused this episode to occur? _____

Does the pain radiate to any other part of your body? (shoulder, mid back, arm, leg, hip, head, etc.) _____

On a scale of 1-10 how would you rate the intensity of your pain? (10 being worst) _____

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

Other: _____

When you are awake, how often is it present? 0-25% of time 26-50% 51-75% 75-100% Constant

Does anything give you relief? _____

Does anything aggravate it or make it worse? _____

Is it better during certain times of the day? _____

Since it began; has it been getting better, staying the same, or getting worse? _____

Have you been treated by any other doctor for this condition? ___ Yes ___No

If yes, by whom? _____ How long ago?: _____

What was the Treatment? _____ Results? _____

Height: _____ Weight: _____ Are You Pregnant? ___Yes ___ No ____ Unsure

Anything else we should know to help you get better as fast as possible? _____

_____

Patient Signature _____ Date _____

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ADDITIONAL COMPLAINT = "What else are we seeing you for today?"

If you have more than one complaint, complete this page also. Please use one section for each complaint.

ONE sheet Per Issue. Example: Neck Pain is one sheet, Low Back would be another sheet, etc.

Thank you for being thorough; it helps us help you. NOTE: If you have low back pain that goes into your mid back, hip or leg one sheet is OK. Same if you have neck pain that runs up into the back of your head or into your shoulder, etc. you can just use one sheet.

Patient Name _____

What is your **ADDIITONAL** health issue? _____

Is this a Flare Up of something you have had before, or is it a New Condition? _____

How long has this been bothering you? _____

What caused this episode to occur? _____

Does the pain radiate to any other part of your body? (shoulder, mid back, arm, leg, hip, head, etc.) _____

On a scale of 1-10 how would you rate the intensity of your pain? (10 being worst) _____

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

Other: _____

When you are awake, how often is it present? 0-25% of time 26-50% 51-75% 75-100% Constant

Does anything give you relief? _____

Does anything aggravate it or make it worse? _____

Is it better during certain times of the day? _____

Since it began; has it been getting better, staying the same, or getting worse? _____

Have you been treated by any other doctor for this condition? ___ Yes ___No

If yes, by whom? _____ How long ago?: _____

What was the Treatment? _____ Results? _____

Anything else we should know to help you get better as fast as possible? _____

_____

Patient Signature _____ Date _____