

**Back on Track Family Chiropractic, LLC**  
**Patient Application**  
*(Please Print. All information is confidential)*

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

**Name:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Marital Status:** M S D W    **# of Children:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Office Phone:** \_\_\_\_\_    **Cell:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**DOB:** \_\_\_\_\_    **Age:** \_\_\_\_\_

**Driver Lic #:** \_\_\_\_\_

**Ages of Kids:** \_\_\_\_\_    **Spouses Name:** \_\_\_\_\_

If patient is a minor, please fill out this section. If not, skip.

Parent/Guardian's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Address (if different than patient's) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Chief complaint or reason for today's visit? \_\_\_\_\_

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:  
**R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling**

How long have you had this condition? \_\_\_\_\_ Date of Onset? \_\_\_\_\_

Have you had this condition before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Is the condition related to: Work ( ) Auto ( ) Date of Accident: \_\_\_\_\_

What doctors have you seen for this condition? \_\_\_\_\_

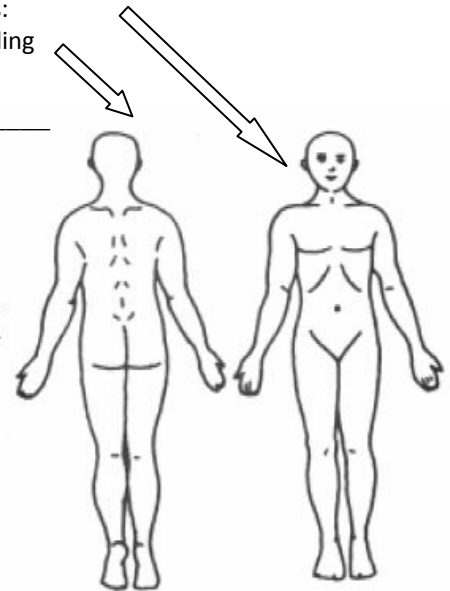
What did they do? \_\_\_\_\_

When was your last visit to a Chiropractor? \_\_\_\_\_ Chiropractor's Name \_\_\_\_\_

What are your health goals? \_\_\_\_\_

What surgeries have you had? \_\_\_\_\_

When was your last auto accident? \_\_\_\_\_



Have you or anyone in your IMMEDIATE family had any of the following conditions?

(Check all that apply)

- |  |                                       |   |   |  |
|--|---------------------------------------|---|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Alzheimers     | <input type="checkbox"/> Muscular Sclerosis  |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Spine Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis     |                                       |   |   |  |

Medications or supplements you are currently taking? (please continue on back if needed)

Name: \_\_\_\_\_ Purpose \_\_\_\_\_ Taking for how long? \_\_\_\_\_

Name: \_\_\_\_\_ Purpose \_\_\_\_\_ Taking for how long? \_\_\_\_\_

Name: \_\_\_\_\_ Purpose \_\_\_\_\_ Taking for how long? \_\_\_\_\_

Name: \_\_\_\_\_ Purpose \_\_\_\_\_ Taking for how long? \_\_\_\_\_

## Back on Track Family Chiropractic, LLC Patient History

Please mark X for present conditions – O for past conditions

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Neck Pain                                | <input type="checkbox"/> Frequent Colds/Flu                          | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Numb/Tingle Pain - arms, hands, fingers  | <input type="checkbox"/> Convulsions! Epilepsy                       | <input type="checkbox"/> Loss of Balance       |
| <input type="checkbox"/> Upper Back Pain                          | <input type="checkbox"/> Cancer                                      | <input type="checkbox"/> Blurred Vision        |
| <input type="checkbox"/> Mid Back Pain                            | <input type="checkbox"/> High Blood Pressure                         | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Low Back Pain                            | <input type="checkbox"/> Low Blood Pressure                          | <input type="checkbox"/> Kidney Trouble        |
| <input type="checkbox"/> Numb/Tingle Pain –legs, feet, toes       | <input type="checkbox"/> Depression                                  | <input type="checkbox"/> Ear Infection         |
| <input type="checkbox"/> Headache                                 | <input type="checkbox"/> Irritable                                   | <input type="checkbox"/> PMS                   |
| <input type="checkbox"/> Hip Pain                                 | <input type="checkbox"/> Anemia                                      | <input type="checkbox"/> Double Vision         |
| <input type="checkbox"/> Difficulty standing, Walking, or Sitting | <input type="checkbox"/> Tremors                                     | <input type="checkbox"/> Pain W/ Cough/Sneeze  |
| <input type="checkbox"/> Difficulty with daily activities         | <input type="checkbox"/> Allergies                                   | <input type="checkbox"/> Foot Trouble          |
| <input type="checkbox"/> Difficulty exercising                    | <input type="checkbox"/> Heartburn                                   | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Impotence/Sexual Dysfunction             | <input type="checkbox"/> Prostate Problems                           | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Fractured Bones                          | <input type="checkbox"/> Bed Wetting                                 | <input type="checkbox"/> Lung Problems         |
| <input type="checkbox"/> Auto Accidents                           | <input type="checkbox"/> Hepatitis (A, B, C)                         | <input type="checkbox"/> Difficulty Breathing  |
| <input type="checkbox"/> Other Accidents/Falls                    | <input type="checkbox"/> Sinus Problems                              | <input type="checkbox"/> Heart Problem         |
| <input type="checkbox"/> Colon Trouble                            | <input type="checkbox"/> Eating Disorder                             | <input type="checkbox"/> Menstrual Problem     |
| <input type="checkbox"/> Pregnant (Now)                           | <input type="checkbox"/> Trouble Sleeping                            | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> ADD/ADHD                                 | <input type="checkbox"/> Learning Disability                         | <input type="checkbox"/> Varicose Veins        |
| <input type="checkbox"/> Back Curvature                           | <input type="checkbox"/> Mood Changes                                | <input type="checkbox"/> Liver Trouble         |
| <input type="checkbox"/> Arthritis                                | <input type="checkbox"/> Difficulty bending or with Household duties | <input type="checkbox"/> Gall Bladder Trouble  |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Shoulder Pain                               | <input type="checkbox"/> Digestive Problems    |
| <input type="checkbox"/> Swollen/Painful Joints                   | <input type="checkbox"/> Dizziness                                   | <input type="checkbox"/> Diarrhea/Constipation |
|   | <input type="checkbox"/> Jaw Pain, TMJ, R L                          | <input type="checkbox"/> Menopausal Problems   |
|   | <input type="checkbox"/> Ringing in Ears                             | <input type="checkbox"/> AIDS/HIV              |
|   | <input type="checkbox"/> Hearing Loss                                | <input type="checkbox"/> Skin Problems         |

**List Your Chief Complaint:** \_\_\_\_\_

(Please circle all that apply to your chief complaint)

Location	Onset	What Makes It Worse?	Type of Pain	Pain Radiating?	Pain Radiating into?	Severity of Pain 1 – 10 (10 Worst)	Time Out of a Week
Left	Today	Everything	Aching	Left	Head	1	10%
Right	This Week	Nothing	Burning	Right	Shoulder	2	20%
Both	This Month	Lifting	Deep	Front	Arm	3	30%
Front	This Year	Working	Dull	Back	Hand	4	40%
Back		Sitting	Numbing		Ribs	5	50%
		Bending	Sharp		Buttocks	6	60%
		Standing	Soreness		Hip	7	70%
		Sneezing	Stabbing		Leg	8	80%
		Coughing	Stiffness		Foot	9	90%
		Tenderness				10	100%
Tingling							

# Back on Track Family Chiropractic, LLC

## Functional Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Daily Activities: Effects of current condition(s) on performance

Care for Family Member	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Change Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Self Care - Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Self Care - Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Exercise/Recreation	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

**PAST HISTORY**

1. If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability  
\_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions:

2. PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing your present problem:

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →		
SURGERIES →		
CHILDHOOD DISEASES→		
ADULT DISEASES →		

Reserved for doctor's use only Systems reviewed with patient:

Musculoskeletal   
 Neurological

**SOCIAL HISTORY**

- 1. Smoking:  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never
- 2. Alcoholic Beverage: consumption occurs →  Daily  Weekends  Occasionally  Never
- 3. Recreational Drug use:  Daily  Weekends  Occasionally  Never
- 4. Hobbies -Recreational Activities- Exercise Regime: How does you present problem affect the following:

IDENTIFY TYPE:	EFFECT:
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform
_____	<input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_



I hereby authorize payment to be made directly to Back on Track Family Chiropractic, LLC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [CLINIC NAME] for any and all services I receive at this office.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed