



Backbone Chiropractic - Health and Wellness Clinic  
Dr. Kristin Batdorf, DC

### Patient Personal Information

Name: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date: \_\_\_\_\_ Work Phone#: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

Are you: Minor Married Divorced Widowed Single Separated Partnered

Your employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who may we call in an emergency? \_\_\_\_\_ Phone#: \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Was this an accident?

Is this condition due to an accident? Yes No Date: \_\_\_\_\_

Type of accident: Auto Work Home Other \_\_\_\_\_

To whom have you reported this accident? Auto Ins. Employer Worker Comp Other

Attorney name (if applicable) \_\_\_\_\_

#### Insurance Information

Name of insured? \_\_\_\_\_ Relationship to patient? \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date employed: \_\_\_\_\_

Name of employer \_\_\_\_\_ Work phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ Group# \_\_\_\_\_ empl.# \_\_\_\_\_

Insurance Co. address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max annual benefit? \_\_\_\_\_

DO YOU HAVE OTHER INSURANCE? NO YES IF YES, PLEASE CONTINUE BELOW

Name of insured? \_\_\_\_\_ Relationship to patient? \_\_\_\_\_

Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Co. address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### Authorization

I certify that I understand the above information and have accurately answered the questions. I authorize the chiropractor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child while receiving chiropractic care in this office to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent if a minor)

Date

## Symptoms

Reason for this visit? \_\_\_\_\_

When did you first notice the symptoms? \_\_\_\_\_

Is this condition getting worse? \_\_\_\_\_

What activities are difficult to perform? Sitting Standing Walking Bending \_\_\_\_\_

Does it interfere with: Work Sleep Daily Routine Recreation

Type of pain? Sharp, Dull, Throbbing, Numbness, Aching, Shooting, Cramps  
Burning, Tingling, Stiffness, Swelling, Other \_\_\_\_\_

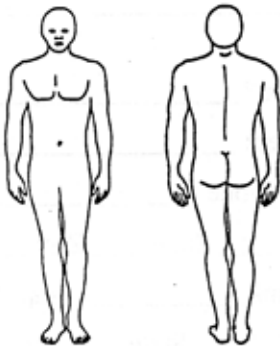
Circle the severity of your pain? 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

(0 being no pain, 10 the worst pain imaginable)

Is the pain constant or does it come and go? \_\_\_\_\_

What treatment have you received for your condition? Medication, Surgery, Physical Therapy  
Other \_\_\_\_\_

Please mark on the diagram specifically where you feel pain?



### Daily Habits

What type of exercise do you perform? How often?

What do your work duties include? \_\_\_\_\_

Do you currently take vitamins/supplements? \_\_\_\_\_

Do you smoke? \_\_\_\_ if so, how much? \_\_\_\_\_

How much liquor do you consume in a week? \_\_\_\_\_

How much coffee/soda do you consume in a day? \_\_\_\_\_

### Health History

Please check only the conditions that are applicable:

AIDS/HIV	cataracts	hepatitis	osteoporosis	suicide attempt
alcoholism	chicken pox	herniated disc	pacemaker	thyroid problems
allergy shots	depression	herpes	pinched nerve	tuberculosis
anemia	diabetes	high cholesterol	pneumonia	tumors/growths
appendicitis	emphysema	kidney disease	polio	typhoid fever
arthritis	epilepsy	liver disease	prostate problems	ulcers
asthma	fractures	measles	prosthesis	vaginal infections
breast lump	goiter	miscarriage	Rheumatoid arthritis	venereal disease
bronchitis	gout	multiple sclerosis	scarlet fever	whooping cough
cancer	heart disease	mumps	stroke	other _____

Date of last physical exam? \_\_\_\_\_

List any surgeries that you have had and the dates on which they occurred: \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_