

# **BACK TO HEALTH CHIROPRACTIC**

**146 WALNUT ST.**

**LAWRENCEBURG, IN 47025**

**(812) 537-7777**

**(812) 537-7094 fax**

**SHANNON W. BARGER, DC**

CASE NO. \_\_\_\_\_

*Please fill out the following form in as much detail as possible. Please print*

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

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone\_(\_\_\_\_)\_\_\_\_\_ Alternate

Phone\_(\_\_\_\_)\_\_\_\_\_

E-mail Address \_\_\_\_\_ Would you like to receive newsletter? Y N

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_ Sex (M)\_\_\_\_(F)\_\_\_\_

How did you hear about us? \_\_\_\_\_

Married \_\_\_ S \_\_\_ W \_\_\_ D \_\_\_ Children \_\_\_ Name of Spouse \_\_\_\_\_

Is any other member of your family being treated in this office? \_\_\_\_\_

Have you ever had chiropractic care before? \_\_\_\_\_

For what problem? \_\_\_\_\_

Previous Chiropractor(s) name / location: \_\_\_\_\_

## **PRESENT COMPLAINT**

Major complaints and symptoms — please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How do you believe your problem (pain) began  
(cause)? \_\_\_\_\_

\_\_\_\_\_

When did you first notice this problem/pain? \_\_\_\_\_

Have you lost any work? \_\_\_\_\_ Day and date you last worked \_\_\_\_\_

Have you ever had this condition before or a similar condition? \_\_\_\_\_

When? \_\_\_\_\_

What positions or activities aggravate your condition? \_\_\_\_\_

What positions or activities relieve your condition? \_\_\_\_\_

Have you ever been treated by a Medical Physician for this ailment? \_\_\_\_\_

Where? \_\_\_\_\_

Family physician's name \_\_\_\_\_

Please send a report to my family physician. Yes \_\_\_\_\_ No \_\_\_\_\_

2.

Have you been treated for any health condition by a physician in the past year?

If yes, what condition? \_\_\_\_\_

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc.

(even as a child)? \_\_\_\_\_ When? \_\_\_\_\_

Have you ever broken any bones? (fractures) \_\_\_\_\_ Any dislocations? \_\_\_\_\_

What operations have you had? \_\_\_\_\_ Year \_\_\_\_\_

\_\_\_\_\_ Year \_\_\_\_\_

\_\_\_\_\_ Year \_\_\_\_\_

Give dates you have had any of the following? (if exact date is unknown, give approximate)

Blood tests \_\_\_\_\_ Urinalysis \_\_\_\_\_

MRI \_\_\_\_\_ CT Scan \_\_\_\_\_ Ultrasound \_\_\_\_\_

X-Ray examination \_\_\_\_\_

Other special treatment \_\_\_\_\_

At what hospital or office were these tests taken \_\_\_\_\_

**REVIEW OF SYSTEMS**

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	<b>Now</b>	<b>Past</b>		<b>Now</b>	<b>Past</b>
	<b>N</b>	<b>P</b>		<b>N</b>	<b>P</b>
Neck Pain / Stiffness	_____	_____	Sleeping Problems	_____	_____
Muscle Spasms	_____	_____	Loss of Smell	_____	_____
Sleeping Problems	_____	_____	Loss of Taste	_____	_____
Back Pain	_____	_____	Rheumatoid Arthritis	_____	_____
Rheumatoid Arthritis	_____	_____	High Blood Pressure	_____	_____
Shoulder/Neck/Arm Pain	_____	_____	Constipation	_____	_____
Pins & Needles in Arms	_____	_____	Heart problems	_____	_____
Pins & Needles in Legs	_____	_____	Cold Sweats	_____	_____
Numbness in Fingers	_____	_____	Fever	_____	_____
Numbness in Toes	_____	_____	Sinus Problems	_____	_____
Knee Pain	_____	_____	Hemorrhoids	_____	_____
Leg Cramps	_____	_____	Chest Pains	_____	_____
Weakness in Arms	_____	_____	Diabetes	_____	_____
Weakness in Legs	_____	_____	Difficulty Urinating	_____	_____
Shortness of Breath	_____	_____	Indigestion	_____	_____
Depression	_____	_____	Vomiting	_____	_____
Kidney Stones	_____	_____	Gallbladder problems	_____	_____
Abdominal Pain	_____	_____	Incontinence	_____	_____
Kidney Infection	_____	_____	Bladder Infection	_____	_____
Mental Illness	_____	_____	Panic Attacks	_____	_____
Swollen Hands or Feet	_____	_____	Blood Clots	_____	_____
Stroke / TIA	_____	_____	Persistent Cough	_____	_____
Ulcers	_____	_____	Heartburn / Reflux	_____	_____

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Do you have vertigo (dizziness)?	Yes _____	No _____
Do you pass out easily (faint or loss of consciousness)?	Yes _____	No _____
Do you have double vision or have you lost sight in one eye?	Yes _____	No _____
Do you have any slurred speech or difficulty with speech?	Yes _____	No _____
Do you have indigestion or difficulty swallowing?	Yes _____	No _____
Do you have any difficulty walking/ coordination /falling?	Yes _____	No _____
Do you have nausea or vomiting?	Yes _____	No _____
Do you have numbness on one side of your face or body?	Yes _____	No _____
Do you have any visual disturbances or rapid eye movement?	Yes _____	No _____
Do you have or have you ever had difficulty in arranging words properly?	Yes _____	No _____
Do you have a headache or head pain that is unlike any you have had before?	Yes _____	No _____
Do you have headaches for hours or days?	Yes _____	No _____
Do you have a history of stroke in your family?	Yes _____	No _____
Do you have chest pain?	Yes _____	No _____
Do you have any change in bowel or bladder habits?	Yes _____	No _____
Do you have a sore that does not heal?	Yes _____	No _____
Do you have any unusual bleeding or discharge?	Yes _____	No _____
Do you have any thickening in your breasts or elsewhere?	Yes _____	No _____
Do you have a nagging cough or hoarseness?	Yes _____	No _____
Do you have night sweats?	Yes _____	No _____
Do you have pain in neck, jaw or face?	Yes _____	No _____
Do you have a drooping eyelid or change in your pupils?	Yes _____	No _____
Do you have any ringing in your ears?	Yes _____	No _____
Do you take birth control pills?	Yes _____	No _____
What prescription medication are you taking if any?		
<input type="checkbox"/> High blood pressure medication		
<input type="checkbox"/> Blood thinners		
<input type="checkbox"/> Herb, vitamins, or over the counter products/ pain relievers		
<input type="checkbox"/> Other _____		
_____		
_____		
_____		

Have you ever had cancer?	Yes ____	No ____
Does your pain ever wake you from a sound sleep?	Yes ____	No ____
Are you losing weight now without trying?	Yes ____	No ____
Are you coughing up blood or noticing it in your stools or urine?	Yes ____	No ____
Have you had any loss of bladder or bowel control?	Yes ____	No ____
Have you lost consciousness or had double vision recently?	Yes ____	No ____
Are you seeing any other doctor now for any reason?	Yes ____	No ____
Condition: _____		

### ***Social History***

SMOKER \_\_\_\_\_ Yes or \_\_\_\_\_ No, If Yes, how many packs \_\_\_\_\_

ALCOHOL \_\_\_\_\_ Yes or \_\_\_\_\_ No, If Yes, how much \_\_\_\_\_

HOBBIES? \_\_\_\_\_

### Family History

Did you mother or father have any of the following:

Put an **M** for mother, **F** for father, and **B** for both.

- |  |  |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer or Stomach Problems   |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Stroke (Please indicate age when stroke occurred,<br>Mother _____ Father _____) |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Arthritis-Rheumatism  |
| <input type="checkbox"/> Seizure-Convulsions | <input type="checkbox"/> Mental Illness  |
| <input type="checkbox"/> HIV Positive        | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Circulation Problems  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Kidney Disease      |  |

### SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

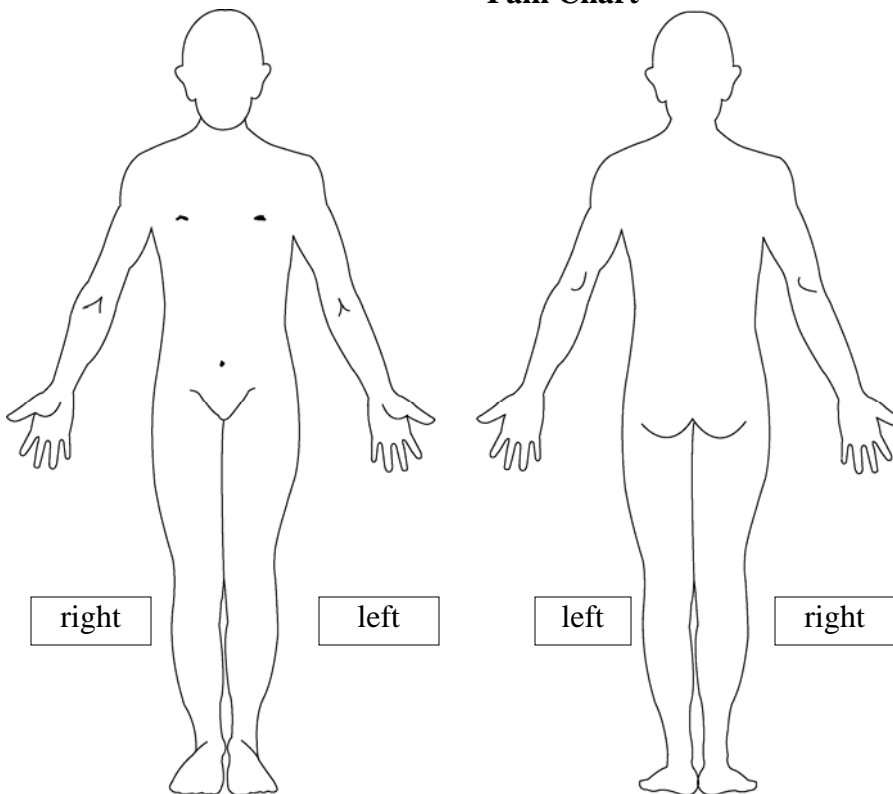
Mark the areas on this body where you feel the described sensations.

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////
-----	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.  
10 being the worst pain you have felt with this condition.

### Pain Chart



#### Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate r discomfort as follows:

( \_\_\_\_\_ )

**0** **10**  
**no pain** **severe pain**

#### Mid Back Pain

On a scale of zero to 10, I rate r discomfort as follows:

( \_\_\_\_\_ )

**0** **10**  
**no pain** **severe pain**

#### Low Back and Leg Pain

On a scale of zero to 10, I rate r discomfort as follows:

( \_\_\_\_\_ )

**0** **10**  
**no pain** **severe pain**

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

Signature \_\_\_\_\_

***BACK TO HEALTH CHIROPRACTIC***

***146 WALNUT ST.***

***LAWRENCEBURG, IN 47025***

***(812) 537-7777***

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***SHANNON W. BARGER, DC***

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

**ASSIGNMENT OF INSURANCE BENEFITS**

I authorize and direct that payment be made directly to:

**DR. SHANNON W. BARGER  
BACK TO HEALTH CHIROPRACTIC  
146 WALNUT ST.  
LAWRENCEBURG, IN 47025**

For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

\_\_\_\_\_  
Date

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

**RELEASE OF INFORMATION.** I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan of Medicare.

\_\_\_\_\_  
Date

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

**PAYMENT AGREEMENT.** I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

\_\_\_\_\_  
Date

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