

**Backstrom Chiropractic Clinic**  
496 Crescent Blvd.  
Glen Ellyn · IL 60137  
Phone 630·790·2440 · Fax 630·790·4202

**Confidential Patient Health Records**

**PATIENT INFORMATION**

**Patient #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  Female  Male

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

Family Status:  Single  Married  Divorced  Widowed

# of children \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employment Status:  Employed  Part-time Student  Full-Time Student  Other \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed by: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Health Insurance Carrier:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **Group #** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_ Insured's S.S. #: \_\_\_\_\_

**Secondary Health Insurance Carrier:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **Group #** \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_ Insured's S.S. #: \_\_\_\_\_

Who is responsible for your bill?  Self Pay  Spouse

Auto Insurance  Worker's Comp  Medicare

This is **NOT** a Work-Related or Worker's Compensation injury

This is **NOT** an Auto Accident related injury

This is **NOT** a Personal Injury case currently under litigation

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST HEALTH HISTORY**

**Surgeries/Indicate Year of Surgery**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> NONE              | <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Hernia Repair        | <input type="checkbox"/> Laminectomy         |
| <input type="checkbox"/> Angioplasty       | <input type="checkbox"/> Carpal Tunnel Repair    | <input type="checkbox"/> Hysterectomy         | <input type="checkbox"/> Pacemaker Insertion |
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Coronary Bypass         | <input type="checkbox"/> Joint Reconstruction | <input type="checkbox"/> Spinal Infusion     |
| <input type="checkbox"/> Caesarean Section | <input type="checkbox"/> Cosmetic                | <input type="checkbox"/> Joint Replacement    | <input type="checkbox"/> Tonsillectomy       |

Spine Surgery: \_\_\_\_\_

Others: \_\_\_\_\_

Ob/Gyne: \_\_\_\_\_

Are you pregnant?  No  Yes Due Date \_\_\_\_\_

**Childhood Illnesses**

- |  |  |                                    |  |
|--|--|------------------------------------|--|
| <input type="checkbox"/> NONE                | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizure Disorder          |
| <input type="checkbox"/> ADD                 | <input type="checkbox"/> Depression          | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Anemia        |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Measles   | <input type="checkbox"/> Spina Bifida              |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fetal Drug Exposure | <input type="checkbox"/> Mumps     | <input type="checkbox"/> Usual Childhood Illnesses |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Food Allergies      | <input type="checkbox"/> Rash      |  |

Other: \_\_\_\_\_

**Adult Illnesses**

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> NONE        | <input type="checkbox"/> CRPS (RSD)              | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Depression              | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Diabetes (insulin dep.) | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Diabetes (noninsulin)   | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> STD's                |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Eye Problems            | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Stroke (CVA)         |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Lung Disease   | <input type="checkbox"/> Thyroid Problems     |

Other: \_\_\_\_\_

**Injuries**

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

\_\_\_\_\_

\_\_\_\_\_

**Treatments**

Description:	Date(s):
<input type="checkbox"/> Chemotherapy	_____
<input type="checkbox"/> Chiropractic	_____
<input type="checkbox"/> Non-surgical treatment	_____
<input type="checkbox"/> Physical Therapy	_____
<input type="checkbox"/> Psychiatric	_____
<input type="checkbox"/> Other	_____

**Current Medications**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

	Age	Significant Illnesses	Deceased/Year	Cause of Death
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Son(s) Number # _____				
Daughter(s) Number # _____				
Brother(s) Number # _____				
Sister(s) Number # _____				

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

## **SOCIAL HISTORY**

### **Substance Usage**

- Alcohol
- Caffeinated beverages
- Recreational drugs
- Smoker
- Lives with smoker

### **Exercise**

- None
- Infrequent
- Occasional
- Limited
- Regular
- Frequent & heavy

### **Medical**

Physical: Indicate Year of most recent

- Irregular Basis
- Last Exam
- Never had one
- Regular Basis
- Regular at work

### **Working Environment**

- No problems
- Above normal noise level
- Repetitive Injury
- Requires constant standing
- Requires lifting \_\_\_\_\_ lbs.
- Exposed Lung pollutant
- Exposed Extreme Temperatures
- Requires heavy typing or data entry
- Stressful

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_  
Incident: \_\_\_\_\_ [office use only]

**INITIAL EVALUATION**  
**CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS**

**Please use the attached pain drawing to mark the area of your primary complaint.**

**Chief Complaint**

What is your primary complaint in what location? \_\_\_\_\_  
Date the symptom first appeared? \_\_\_\_\_

**Quality**

**Pain Quality Scale**

Type of pain (check all that apply):

- none aching burning constant cramping dull stiffness intermittent mild  
moderate persistent severe sharp shooting stabbing swelling throbbing  
numbness tingling other \_\_\_\_\_

Does the pain travel or radiate? Into arm R or L Into leg R or L Other \_\_\_\_\_

Rate the level of your pain/symptoms from 0, no pain/no symptoms, to 10, unbearable pain/symptoms:  
Circle one: 0 1 2 3 4 5 6 7 8 9 10

**Severity**

How frequent is this condition?

- acute chronic dull frequent improved improving increased increasing  
infrequent mild moderate w/movement never occasional persistent severe  
stabbing

**Timing**

What makes the condition better? \_\_\_\_\_

What makes the condition worse? \_\_\_\_\_

**Pain:** When do you experience the pain?

- in morning end of day later in the day at night various times

**Symptoms:** How did the condition begin?

- Gradually Suddenly Progressively over time

**Context**

Explain why or how the condition began: \_\_\_\_\_

**Condition interferes:**

What does this condition prevent you from doing? \_\_\_\_\_

**Modifying Factors:**

For this condition, I have been:

- Never been treated Hospitalized Treated by another chiropractor Treated by another provider

**Associated Symptoms**

Are there any other conditions or symptoms that may be related to your major complaint?

- No Yes If yes, please explain \_\_\_\_\_

Are there any other unrelated health problems or symptoms?

- No Yes If yes, please explain \_\_\_\_\_

# Medical Symptoms Questionnaire

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

- Point scale
- 0 – *Never or almost never* have the symptoms  
 1 – *Occasionally* have it, effect is *not severe*  
 2 – *Occasionally* have it, effect is *severe*  
 3 – *Frequently* have it, effect is *not severe*  
 4 – *Frequently* have it, effect is *severe*

- Head**    \_\_\_\_\_ Headaches  
           \_\_\_\_\_ Faintness  
           \_\_\_\_\_ Dizziness  
           \_\_\_\_\_ Insomnia  
           \_\_\_\_\_ **Total**

- Eyes**    \_\_\_\_\_ Watery or itchy eyes  
           \_\_\_\_\_ Swollen, reddened, or sticky eyelids  
           \_\_\_\_\_ Bags or dark circles under eyes  
           \_\_\_\_\_ Blurred or tunnel vision  
                   (does not include near- or far-sightedness)  
           \_\_\_\_\_ **Total**

- Ears**    \_\_\_\_\_ Itchy Ears  
           \_\_\_\_\_ Earaches, ear infection  
           \_\_\_\_\_ Drainage from ear  
           \_\_\_\_\_ Ringing in ears, hearing loss  
           \_\_\_\_\_ **Total**

- Nose**    \_\_\_\_\_ Stuffy Nose  
           \_\_\_\_\_ Sinus Problems  
           \_\_\_\_\_ Hay Fever  
           \_\_\_\_\_ Sneezing attacks  
           \_\_\_\_\_ Excessive mucus formation  
           \_\_\_\_\_ **Total**

- Mouth/Throat**    \_\_\_\_\_ Chronic coughing  
                   \_\_\_\_\_ Gagging, frequent need to clear throat  
                   \_\_\_\_\_ Sore throat, hoarseness, loss of voice  
                   \_\_\_\_\_ Swollen or discolored tongue, gums, lips  
                   \_\_\_\_\_ Canker sores  
                   \_\_\_\_\_ **Total**

- Skin**    \_\_\_\_\_ Acne  
           \_\_\_\_\_ Hives, rashes, dry skin  
           \_\_\_\_\_ Hair loss  
           \_\_\_\_\_ Flushing, hot flashes  
           \_\_\_\_\_ Excessive sweating  
           \_\_\_\_\_ **Total**

- Heart**    \_\_\_\_\_ Irregular or skipped heartbeat  
           \_\_\_\_\_ Rapid or pounding heartbeat  
           \_\_\_\_\_ Chest pain  
           \_\_\_\_\_ **Total**

- Lungs**    \_\_\_\_\_ Chest congestion  
           \_\_\_\_\_ Asthma, bronchitis  
           \_\_\_\_\_ Shortness of breath  
           \_\_\_\_\_ **Total**

- Digestive Tract**    \_\_\_\_\_ Nausea, vomiting

- \_\_\_\_\_ Diarrhea  
 \_\_\_\_\_ Constipation  
 \_\_\_\_\_ Bloating feeling  
 \_\_\_\_\_ Belching, passing gas  
 \_\_\_\_\_ Heartburn  
 \_\_\_\_\_ Intestinal/stomach pain  
 \_\_\_\_\_ **Total**

- Joints/Muscle**    \_\_\_\_\_ Pain or aches in joints  
                   \_\_\_\_\_ Arthritis  
                   \_\_\_\_\_ Stiffness or limitation of movement  
                   \_\_\_\_\_ Pain or aches in muscles  
                   \_\_\_\_\_ Feeling of weakness or tiredness  
                   \_\_\_\_\_ **Total**

- Weight**    \_\_\_\_\_ Binge eating/drinking  
                   \_\_\_\_\_ Craving certain foods  
                   \_\_\_\_\_ Excessive weight  
                   \_\_\_\_\_ Compulsive eating  
                   \_\_\_\_\_ Water retention  
                   \_\_\_\_\_ Underweight  
                   \_\_\_\_\_ **Total**

- Energy/Activity**    \_\_\_\_\_ Fatigue, sluggishness  
                   \_\_\_\_\_ Apathy, lethargy  
                   \_\_\_\_\_ Hyperactivity  
                   \_\_\_\_\_ Restlessness  
                   \_\_\_\_\_ **Total**

- Mind**    \_\_\_\_\_ Poor memory  
                   \_\_\_\_\_ Confusion, poor comprehension  
                   \_\_\_\_\_ Poor concentration  
                   \_\_\_\_\_ Poor physical coordination  
                   \_\_\_\_\_ Difficulty in making decisions  
                   \_\_\_\_\_ Stuttering or stammering  
                   \_\_\_\_\_ Slurred speech  
                   \_\_\_\_\_ Learning disabilities  
                   \_\_\_\_\_ **Total**

- Emotions**    \_\_\_\_\_ Mood swings  
                   \_\_\_\_\_ Anxiety, fear, nervousness  
                   \_\_\_\_\_ Anger, irritability, aggressiveness  
                   \_\_\_\_\_ Depression  
                   \_\_\_\_\_ **Total**

- Other**    \_\_\_\_\_ Frequent illness  
                   \_\_\_\_\_ Frequent or urgent urination  
                   \_\_\_\_\_ Genital itch or discharge  
                   \_\_\_\_\_ **Total**

\_\_\_\_\_ **GRAND TOTAL**

# PAIN DRAWING

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

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

Date symptoms began and/or date of injury: \_\_\_\_\_

1. Please mark **area(s)** of injury or discomfort using the following symbols:

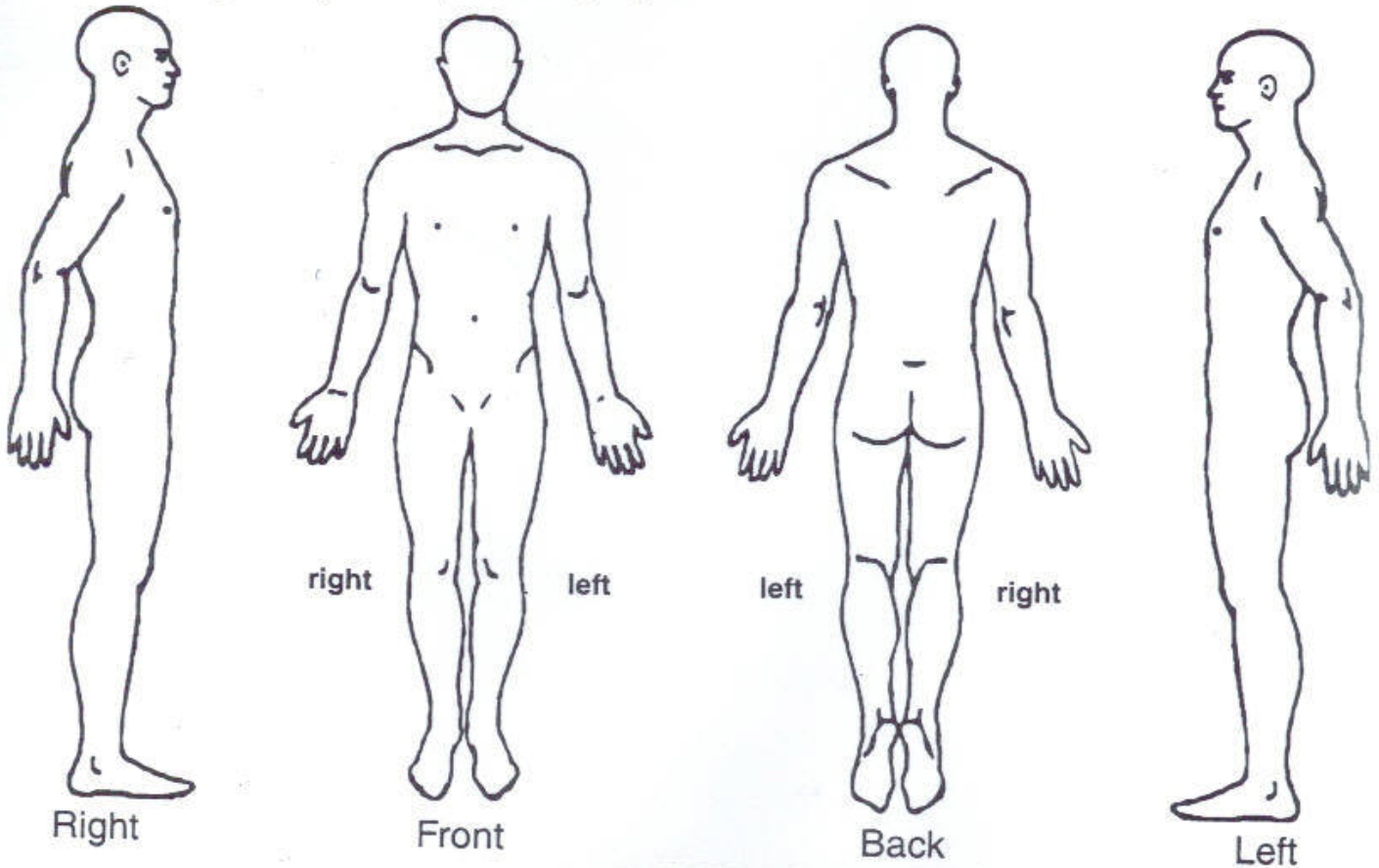
Type of pain:

Ache   Dull   Stiffness   Sharp   Stabbing   Shooting   Swelling   Cramping  
 A       D       S       SH       ST       SS       SW       C

Burning   Throbbing   Numbness   Tingling   Other \_\_\_\_\_  
 B           TH           N           T

2. Indicate all scars from surgery or injury using the following symbol: †

3. Circle any area of pain not represented by a symbol.



On a scale of 0-10, please circle the level that most accurately represents your pain.

0 = No pain      10 = Unbearable Pain

Right Now	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10