BACK TO HEALTH
CHIROPRACTIC & WELLNESS

3700 Barron Way, Ste 3, Reno NV 89511
P: 775-826-5800 F: 775-826-8466
Email:renobacktohealth@gmail.com

Name: _____ Pronoun: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ cell/home Appointment reminders? **Text or Email?**

Email Address: _____ Social Security Number: _____

Spouse/Significant Other's Name: _____ Phone #:_____

Sex: *M F* Marital Status: *M S D W* Your Date of Birth: _____ Age: _____

Occupation: _____

Employer: _____

Emergency Contact and Phone Number: _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No If yes, when? _____

Auto Insurance Co: _____ Agent/Adjuster Name: _____

Agent/Adjuster Phone #: _____ Agent/Adjuster Email: _____

Policy Holder's Name (if other than self): _____ Policy #: _____

How Did You Hear About Us? (who may we thank?)

Referred by: ☐ Family/Friend: _____ ☐ Google ☐ Yelp ☐ Social Media

☐ Health Professional: _____ ☐ Attorney: _____

Information About Your Attorney:

Name:_____ Phone: _____Fax: _____

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

Information About Your Accident:

Date: _____ Time of day: _____ Number of people in your vehicle: _____

Were you: ☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Middle Rear Passenger

☐ Right Rear Passenger ☐ Wearing Seatbelt ☐ Wearing Glasses/Hat

Where were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Did you brace for the impact: ☐ Yes ☐ No

Did the airbag deploy: ☐ Yes ☐ No

Headrest Position: ☐ Even with Top of Head ☐ Even with Bottom of Head ☐ Middle of Neck

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Did you strike anything in car: ☐ Wheel ☐ Windshield ☐ Arm Rest ☐ Dashboard ☐ Side Door ☐ Airbag

Where were your hands: ☐ Both on Wheel ☐ One Hand on Wheel

What direction were you looking: ☐ Front ☐ To the Left ☐ To the Right ☐ Rearview ☐ Lap

Approximate speed of your car: _____ **Approximate speed of the other car:** _____

How was the visibility on the road: ☐ Good ☐ Fair ☐ Poor

How was the weather: ☐ Clear ☐ Raining ☐ Windy ☐ Foggy ☐ Snowy

Did you lose consciousness: ☐ Yes ☐ No If yes, approximately how long? _____

Were police notified: ☐ Yes ☐ No If yes, is there a police report? _____

Were there any witnesses: ☐ Yes ☐ No Names: _____

Estimated damage to vehicle: _____ Who provided the estimate: _____

In your own words, please describe the accident:

_____

_____

_____

_____

Please draw a picture of the motor vehicle accident:

Were you taken to a hospital after your current accident? ☐ Yes ☐ No

What hospital: _____

Name(s) of treating physician(s): _____

Was imaging performed (x-ray, CT, MRI)?: _____

List all the health professional(s) seen since your accident: _____

Information About Your Symptoms:
Please describe how you felt:

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During the Accident: _____ Immediately After: _____

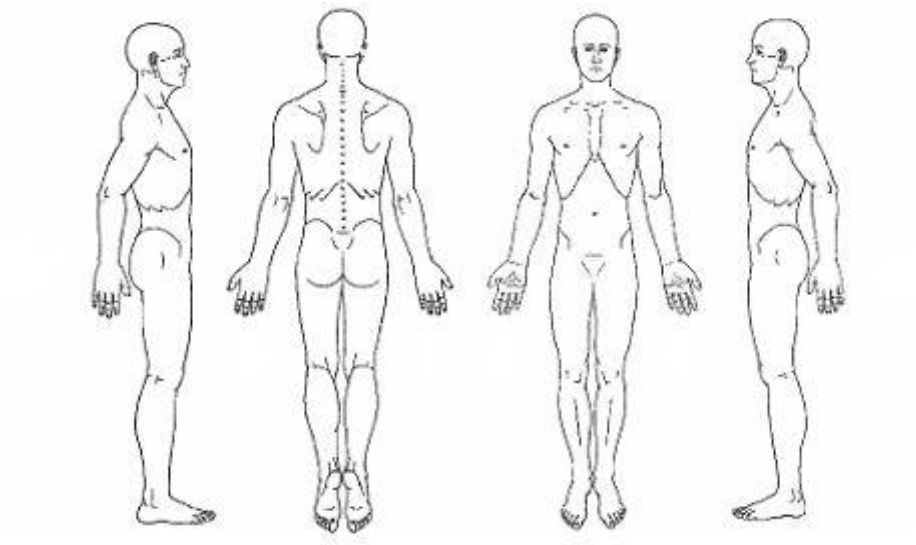
Later that Day: _____ The Next Day: _____

What are your **PRESENT** complaints and symptoms?

_____

_____

Since the injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same



Please check all symptoms you have noticed since the accident:

☐ Headaches	☐ Irritability	☐ Radiating Pain	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Constipation	☐ Loss of Balance	☐ Fainting
☐ Stomach Upset	☐ Sleeping Problems	☐ Head is Heavy	☐ Depression	☐ Fatigue
☐ Back Pain	☐ Cold Sweats	☐ Light Sensitive Eyes	☐ Loss of Smell	☐ Fever
☐ Nervousness	☐ Loss of Memory	☐ Loss of Taste	☐ Diarrhea	☐ Tension
☐ Numbness (up. ext)	☐ Numbness (low. ext)	☐ Ears Ringing	☐ Pins/Needles (arms or legs)	

Symptoms other than above: _____

- On a scale from 0-10, with 10 being the worst; **what number** best describes your symptom most of the time (mark one): 1 2 3 4 5 6 7 8 9 10

- What **percentage of the time** you are awake do you experience the above symptom(s) at the above intensity (mark one):
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom(s) begin **immmediately** or **gradually**? (mark one)

- Is it getting **better, worse** or the **same?** (mark one)

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- When/how did the symptom(s) **begin**?

  _____

  _____

- What are you having **problems** with? (mark all that apply):
  - Seeing, hearing, reading, holding, walking, kneeling, lifting, sitting, sports, reclining, insomnia, loss of concentration, change in personality, tasting, bathing, typing, pinching, stooping, bending, pushing, driving, exercising, restful sleep, using the toilet, smelling, grooming, writing, standing, squatting, twisting, pulling, riding in car, loss of sexual drive, nervous, tactile feeling, eating, dressing, grasping, leaning, climbing, carrying, reaching, air travel, irritable, getting up from seated position, nothing, other (please describe): _____

- What makes the symptom(s) **better**? (mark all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe):

    _____

- Describe the **quality** of the symptom(s) (mark all that apply):
  - Dull, sharp, achy, shooting, spasm, throbbing, burning, numbing, tingling
  - Other (please describe): _____

- Does the symptom(s) **radiate** to another part of your body (mark one): yes no
  - If yes, where does the symptom radiate? _____

- Is the symptom(s) **worse** at certain times of the day or night? (mark all that apply)
  - No difference Morning Afternoon Evening Night Other:_____

- Are you able to **sleep without** pain? yes no
  - Does it **wake** you? yes no
  - Did you have trouble sleeping **before**? yes no

- Have you received **other** treatment for this condition and episode prior to today's visit?

  _____

  (NSAIDS, pain rx, muscle relaxers, trigger point injections, prolotherapy, surgery, massage, PT, chiropractic, etc.)

Do you notice any activity restrictions as a result of this accident? ☐ Yes ☐ No
If yes, please describe: _____

Did you have any physical complaints **before** the accident? ☐ Yes ☐ No
If yes, please describe: _____

Have you ever been involved in an accident before? ☐ Yes ☐ No
If yes, please describe **(include dates, types and injuries received):**

_____

_____

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Past Health History:

Have you had any of the following **pulmonary (lung-related)** issues? ☐ None

Asthma	Emphysema	Other:
COPD	Other:	Other:

Have you had any of the following **cardiovascular (heart-related)** issues or procedures? ☐ None

Angina/chest pain	Heart disease/problems	Murmurs/valve disease
Congestive heart failure	Hypertension	Other:
Heart attacks/MIs	Irregular heartbeat	Other:

Have you had any of the following **neurological (nerve-related)** issues? ☐ None

Headaches	Memory loss	Vertigo
Loss of smell/taste	Seizures	Visual changes/loss of vision
One-side weakness face/body	Strokes/TIA	Other:
One-side decreased feeling in face/body	Tremors	Other:

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures? ☐ None

Diabetes	Injectable steroid replacements	Other:
Endometriosis	Painful periods	Other:
Hormone replacement therapy	Thyroid disease	Other:

Have you had any of the following **renal (kidney-related)** issues or procedures? ☐ None

Bladder infections	Hematuria (blood in urine)	Renal calculi/stones
Dialysis	Incontinence	Other:
Difficulty urinating	Kidney disease	Other:

Have you had any of the following **gastroenterological (stomach-related)** issues? ☐ None

Bloody/black stools	Gastroesophageal reflux/heartburn	Ulcerative disease
Bowel incontinence	Hepatitis/liver disease	Pancreatic disease
Constipation	Hiatal hernia	Vomiting
Difficulty swallowing	Irritable bowel/colitis	Other:
Frequent abdominal pain	Nausea	Other:

Have you had any of the following **hematological (blood-related)** issues? ☐ None

Abnormal bleeding/bruising	Hemophilia	Regular aspirin use
Anemia	HIV positive	Sickle-cell anemia
Anticoagulant therapy	Hypercoagulation/ DVT/blood clots	Other:
Enlarged lymph nodes	Regular anti-inflammatory use	Other:

Have you had any of the following **oncological (cancer-related)** issues? ☐ None

Abnormal bleeding/bruising	Fever/chills/sweats/unexplained weight loss	Other:
Cancer:	Other:	Other:

Have you had any of the following **dermatological (skin-related)** issues? ☐ None

Psoriatic disorders	Significant rashes	Other:
Significant burns	Skin grafts	Other:

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Have you had any of the following **musculoskeletal (bone/muscle-related)** issues? ☐ None

Arthritis (unknown type)	Metal implants	Spinal surgery
Broken bones	Osteoarthritis	Other:
Gout	Rheumatoid arthritis	Other:
Joint surgery	Scoliosis	Other:

Have you had any of the following **psychological** issues? ☐ None

Bipolar disorder	Psychiatric	Schizophrenia
Depression	Psychiatric hospitalizations	Other:
Homicidal ideations	Suicidal ideations	Other:

Is there anything else in your past medical history that you feel is important to your care here?

_____

_____

_____

Surgeries: (if applicable, write year in the adjacent box) ☐ None

Abdominal Exploration		Hemorrhoid Surgery	
Abdominoplasty		Hernia Repair	
Abortion		Hip Replacement	
ACL Reconstruction		Hysterectomy	
Adenoid Removal		Kidney Transplant	
Angioplasty		Knee Arthroscopy	
Appendectomy		Knee Replacement	
Bunion Removal		LASIK	
Carotid Artery Surgery		Liposuction	
Cataract Surgery		Lumbar Spine Surgery	
Cervical Spine Surgery		Mastectomy	
Cholecystectomy		Prostate Removal	
Cosmetic Breast Surgery		Rotator Cuff Surgery	
C-Section		TMJ Surgery	
Facelift		Tonsillectomy	
Gastric Bypass		Vasectomy	
Heart Surgery		Other:	

Previous Injury or Trauma:

_____

(falls, accidents, sports, etc.)

Allergies: (mark all that apply) ☐ None

Acetaminophen	Fragrance	Pollen
Adhesive Tape	Ibuprofen	Soy
Barbiturates	Insulin	Sulfa
Bee/Yellow Jacket Stings	Iodine	Tobacco Smoke
Dairy	Latex	Wheat/Gluten
Dust Mites	Mold	Other:
Eggs	Nuts	Other:
Fish/Shellfish/Seafood	Pet Dander	Other:

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Family Health History: (mark all that apply) ☐ None

Cancer	Heart disease	Other:
Cardiac disease below age 40	Neurological diseases	Other:
Diabetes	Psychiatric disease	Other:
Headaches	Strokes	Adopted/Unknown

Medications: (mark if currently taking) ☐ None

Advil/NSAIDS	Gabapentin
Ambien	Statin Medications
Aspirin	Tylenol
Blood Pressure Medications	Vicodin/Other Pain Medication
Daily Vitamins	Other:
Diabetes Medications	Other:
Flexeril/Muscle Relaxers	Other:

Height: _____ Weight: _____

Social and Occupational History:

A. Job description: _____
(what level of satisfaction do you have in your job?)

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:
Level of Exercise: _____

Alcohol Use: _____

Tobacco/Drug Use: _____

Information About Your Occupation:
Have you lost time from work due to this accident? ☐ Yes ☐ No

Type of employment: _____

Last day you worked: _____

Present Salary: _____

Are you being compensated for time lost from work? ☐ Yes ☐ No

If yes, type of compensation you are receiving: _____

_____ _____ _____
Patient's Printed Name Signature of Patient (guardian signature if patient is under 18) Date

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NECK BOURNEMOUTH QUESTIONNAIRE (Bolton JE, Humphreys BK: The Bournemouth Questionnaire)

Patient Name: _____ Date: _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. **Over the past week, on average, how would you rate your neck pain?**

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. **Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?**

No interference Unable to carry out

0 1 2 3 4 5 6 7 8 9 10

3. **Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?**

No interference Unable to carry out

0 1 2 3 4 5 6 7 8 9 10

4. **Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?**

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. **Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?**

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. **Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?**

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. **Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?**

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

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BACK BOURNEMOUTH QUESTIONNAIRE (Bolton JE, Breen AC: The Bournemouth Questionnaire)

Patient Name: _____ Date: _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

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Effective April 2023

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive this care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one to one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its consent and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient's Printed Name	Signature of Patient (guardian signature if patient is under 18)	Date

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Notice of Privacy Practices (HIPAA Consent Form)
Effective April 2023

By signing below, I understand that some of my health information may be used/and or disclosed by Back to Health Chiropractic and Wellness to carry out treatment, payment, or healthcare operations. For a more complete description of such uses and disclosures I should refer to Back to Health Chiropractic and Wellness's privacy notice entitled "HIPAA Notice of Privacy Practices". I understand that I may view this notice any time prior to signing this form.

This notice describes how health information about you may be used and disclosed and how you can get access to this information, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:
1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain in accordance to changes in the law. All changes in this Notice will be prominently displayed and available at our office.

You have the right to:
• Get a copy of your medical record
• Correct your medical record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information with
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

We will never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information
• Most sharing of chiropractic and treatment notes

Our responsibilities:
• We are required by law to maintain the privacy and security of your protected health information
• We will let you know if a breach occurs that may have compromised the privacy or security of your information
• We must follow the duties and privacy practices described in this notice and give you a copy of it if requested
• We will not use or share your information other than that is described here unless you tell us in writing.

Check one:
☐ Back to Health Chiropractic and Wellness does NOT have my permission to share my information.

☐ Back to Health Chiropractic and Wellness CAN release my applicable information to _____
(name of individual)

_____ _____ _____
Patient's Printed Name | Signature of Patient (guardian signature if patient is under 18) | Date