



**THE BACK AND JOINT CLINIC, P.C.**

**PATIENT INFORMATION:**

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

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

**D.O.B.:** \_\_\_\_\_ **Age:** \_\_\_\_ **Sex:** \_\_\_M \_\_\_F **Occupation:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Employed By:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Work Address:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **City:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Marital Status:** \_\_\_Single \_\_\_Married  
\_\_\_Widowed **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Emergency Contact Information:**

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

**Phone #:** (\_\_\_\_) \_\_\_\_\_

**COMPLAINTS:**

**Please list your complaints in order of their severity:**

**Do you have any additional comments?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Have you seen a chiropractor before?** \_\_\_\_  
**Name of Doctor:** \_\_\_\_\_  
**Name of Clinic:** \_\_\_\_\_  
**How were you referred to our clinic?**  
\_\_\_\_\_

**MEDICAL HISTORY:**

Please check any of the following Illnesses  
You have or have had:

- Arthritis
- Asthma
- Sinus Trouble
- Hay Fever
- Allergies
- Tuberculosis
- Diabetes
- Epilepsy
- Thyroid Trouble
- High Blood Pressure
- Low Blood Pressure
- Heart Trouble
- Pacemaker
- Kidney Trouble

- Sexually Transmitted Disease
- Ulcer
- Cancer
- Polio
- Rheumatic Fever
- Serious Injury: \_\_\_\_\_
- Bone Fracture: \_\_\_\_\_
- Dislocated Joints: \_\_\_\_\_
- Spinal Disc Disease
- Multiple Sclerosis
- Scoliosis
- Mental/Emotional Difficulty
- Prostate Trouble
- Other: \_\_\_\_\_

**SYMPTOMS:**

Please check any of the following Symptoms  
You have now or that come and goes:

- Headaches
- Pain in ears
- Ringing in ears
- Hearing Loss
- Head feels heavy
- Loss of memory
- Loss of taste
- Loss of smell
- Loss of balance
- Dizziness
- Fainting spells
- Blurring of vision
- Light bothers eyes
- Jaw pops or clicks
- Can't eat certain foods
- Allergies

- Fatigue
- Generally run down
- Nervous
- Irritable
- Recent weight gain
- Recent weight loss
- Difficulty swallowing
- Difficulty chewing
- Shortness of breath
- Chest pain
- Tension
- Sleeping problems
- Face flushed
- Pins & Needles
- Fever
- Depression

- Palpitations
- Foot/Ankle swelling
- Leg cramps walking
- Leg cramps sleeping
- Persistent cough
- Coughing up blood
- Coughing up sputum
- Abdominal pain
- Vomiting blood
- Passing blood in stool
- Chronic diarrhea
- Chronic constipation
- Cold sweats
- Hand(s) cold
- Foot (Feet) cold
- Numbness in hands/feet

**MEN ONLY:**

- Difficulty starting to urinate
- Urinate more frequently than usual
- Wake to urinate more than once/night

**WOMEN ONLY:**

- Increased menstrual pain
- Irregular periods
- Birth control pills or IUD
- Pregnant or possibly so

# *The Back and Joint Clinic, P.C.*

## **Health History:**

Have you seen another doctor for this condition? \_\_\_\_ Yes \_\_\_\_ No

Name of doctor: \_\_\_\_\_

Treatment Provided: \_\_\_\_\_

Have you had any surgeries? \_\_\_\_ Yes \_\_\_\_ No

If yes, what was the surgery and when did it occur? \_\_\_\_\_

\_\_\_\_\_

Are you taking any medications? \_\_\_\_ Yes \_\_\_\_ No

If yes, please name the medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_ Yes \_\_\_\_ No

If yes, how many cigarettes per day? \_\_\_\_\_

Do you play any sports or exercise regularly? \_\_\_\_ Yes \_\_\_\_ No

If yes, what activity and how many hours per week? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any major vehicle collisions or any other major injuries: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Anything else Dr. Barcewski should know about? \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# *The Back and Joint Clinic, P.C.*

## **INSURANCE INFORMATION:**

### **Is Your Condition Due To:**

An Automobile Accident? \_\_\_\_ A Personal Injury? \_\_\_\_ A Job Injury? \_\_\_\_

### **Do You Have Health Insurance?**

Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Name Of The Primary Insured: \_\_\_\_\_

Type Of Coverage?

HMO: \_\_\_\_\_

PPO: \_\_\_\_\_

### **Authorization To Release Records To Patient's Insurance Carrier:**

\_\_\_\_\_  
(Patient or Guardian's Signature)

## **PAYMENT AGREEMENT:**

I agree that I am responsible for all expenses incurred at The Back and Joint Clinic, P.C. If I have insurance, I understand that my insurance benefits exist as part of a contract between me and my insurance company, and that The Back and Joint Clinic, P.C. may provide insurance billing as a convenience to me. As part of this service, The Back and Joint Clinic, P.C. will call my insurance company to obtain my policy terms and coverage for chiropractic and/or massage therapy. I understand that, despite our best efforts, it is possible that inaccurate information will be given by my insurance company regarding my policy terms and coverage. If proper procedures are followed, I will not hold The Back and Joint Clinic, P.C. liable for incorrect information received by my insurance company.

I hereby authorize payment directly to The Back and Joint Clinic, P.C. and/or Mark Barcewski, D.C. all insurance benefits otherwise payable to me for services rendered. I authorize The Back and Joint Clinic, P.C. to release any information required to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

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

**Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_