

# BACK IN ACTION HEALTH RESOURCE CENTER

Name: (F) \_\_\_\_\_ (M) \_\_\_\_\_ (L) \_\_\_\_\_

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

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ (Home / Cell / Work)

Secondary Phone Number: \_\_\_\_\_ (Home / Cell / Work)

Other Phone Number: \_\_\_\_\_ (Home / Cell / Work)

Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

May we contact/send report to above named physician? YES / NO

Date of last physical exam: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Results of concern? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Do you know today's winning lottery number? YES (please print clearly) \_\_\_\_\_

How would you rate your overall health?

\_\_\_\_ Excellent    \_\_\_\_ Good    \_\_\_\_ Poor    \_\_\_\_ Getting Better    \_\_\_\_ Getting Worse

## WHY ARE YOU HERE?

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

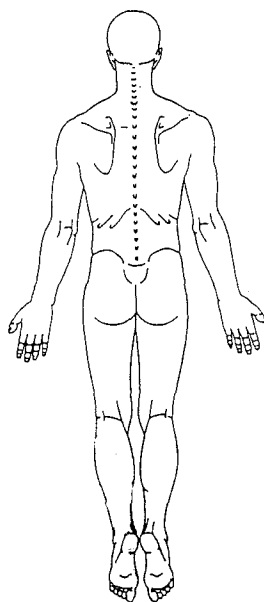
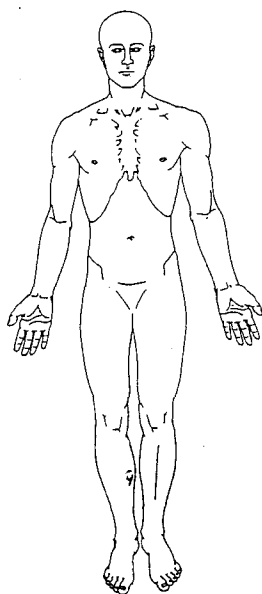
On a scale of 0-10, please circle your current level of pain.

0	1	2	3	4	5	6	7	8	9	10
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None-----low pain-----moderate pain-----intense pain-----unbearable

Use the letters and diagrams below to indicate the type and location of your sensations

A=Ache    B=Burning    N=Numbness    P=Pins and Needles    S=Stabbing    O=Other



Do you have any of the following?

Painful: jaw / neck / back / shoulder / elbow / wrist / hand / hip / ankle / foot

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Hearing Aid        | <input type="checkbox"/> Menstrual Irregularities |
| <input type="checkbox"/> Dentures   | <input type="checkbox"/> Ringing in Ears    | <input type="checkbox"/> Constipation             |
| <input type="checkbox"/> PMS        | <input type="checkbox"/> Contact Lenses     | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Artificial Arms/Legs     |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Sleep Problems     | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Skin Sensitivity   | <input type="checkbox"/> High Cholesterol         |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sense of humor           |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Urinary Problems   |   |

Are you pregnant? YES / NO / N/A

Any surgeries? \_\_\_\_\_

Auto injuries? \_\_\_\_\_

Do you have a family history of:

Cancer / Diabetes / Heart Disease / Arthritis / Osteoporosis / Stroke

Have you had prior experience with:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chiropractic?<br>When? _____ | <input type="checkbox"/> Physical Therapy?<br>When? _____ | <input type="checkbox"/> Professional Massage?<br>When? _____ |
|---|---|---|

List all prescription and over the counter medication that you take:

\_\_\_\_\_

List all vitamins and supplements that you routinely take:

\_\_\_\_\_

Do you:

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Smoke?       | <input type="checkbox"/> Drink coffee?      | <input type="checkbox"/> Consume alcohol? |
| <input type="checkbox"/> Soft Drinks? | <input type="checkbox"/> Drink water daily? |   |

How old is your mattress? \_\_\_\_\_ How many pillows do you use? \_\_\_\_\_

Do you sleep on your... side / back / stomach?

What is your current exercise program? \_\_\_\_\_

Do you play golf? YES / NO

Does your partner/spouse play? YES / NO

Are you aware of our InnerSWING golf performance program? YES / NO

**WHAT DO YOU HOPE TO ACHIEVE FROM YOUR EXPERIENCE AT BACK IN ACTION?**

\_\_\_\_\_

\_\_\_\_\_

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