Name _____ Date _____

CHECK OFF WHICH OF THE FOLLOWING OCCURRED AT LEAST ONCE IN THE PAST 30 DAYS:

Pain			**Decreased Motion**			**Swelling**			**Other Problems**
___ Knee	R	L	___ Knee	R	L	___ Knee	R	L	___ Overweight
___ Shoulder	R	L	___ Shoulder	R	L	___ Shoulder	R	L	___ Diabetes
___ Hip	R	L	___ Hip	R	L	___ Hip	R	L	___ Digestive Problems
___ Ankle	R	L	___ Ankle	R	L	___ Ankle	R	L	___ Dizziness
___ Elbow	R	L	___ Elbow	R	L	___ Elbow	R	L	___ Fatigue
___ Back			___ Back			___ Back			___ Balance Problems
___ Neck			___ Neck			___ Neck			___ Neuropathy
___ Wrist	R	L	___ Wrist	R	L	___ Wrist	R	L	___ Sleep Problems
___ Hand	R	L	___ Hand	R	L	___ Hand	R	L	___ Other _____
									_____

Which health problem bother you the most? _____

On a scale of 1-1, at it's worst, how bad does it get? (1=low, 10=high) _____

How often does it bother you? _____

How long have you had the problem? _____

What could you do before this problem you cannot do now? _____

HOW DOES THE PROBLEM ADDECT YOU?

- ☐ Moodiness/Irritability
- ☐ Decreased Energy
- ☐ Restricted Activity
- ☐ Burden to My Family
- ☐ Interfered with Exercise/ Hobbies
- ☐ Reduced Enjoyment of Life

Back To Health Pre-qualification Application

Personal Information

First Name:_____

Last Name:_____

Social Security Number:_____

Date of Birth:_____

Street Address:_____

City:_____

State:_____

ZIP Code:_____

Contact Information

Mobile Phone:_____

Email Address:_____

If you are planning on using Health Insurance, please provide the following:

Health Insurance Company: _____

Member/ID #: _____ Group #: _____

Customer Service Phone #: _____

Financial Information

**The following information can help us find the right payment solution for you today regardless of your credit history.*

The following best describes my credit history: ☐ Excellent ☐ Less than excellent

☐ I prefer to use my own resources and/or credit and do not wish to disclose my financial information at this time.

Estimated Gross Household Annual Income:

☐Less than $25,000 ☐$25,000-$50,000 ☐$50,000-$75,000 ☐$75,000 or more $_____

Signature: _____ **Date**:_____

Additional Information is requested to process the right payment solution for you.

Driver's License Number/State ID #: _____

Alternative Phone #: _____

GreenSky® Patient Solutions

☐ **You, the Applicant agree and understand the following notice:**

- You are providing written instructions to the GreenSky® Program under the Fair Credit Reporting Act authorizing the GreenSky® Program to obtain information from your personal credit profile or other information from Experian. You authorize the GreenSky® Program to obtain such information solely to conduct a pre-qualification for credit. GreenSky® may share the pre-qualification decision with your healthcare provider.
- You have read, understand, and accept GreenSky's Terms of Use (https://www.greensky.com/terms/website_terms_of_use.pdf) and GreenSky's Privacy Notice. (https://www.greensky.com/privacy-policy/) and GreenSky's Consent to Electronic Records and Communication (https://www.greenskycredit.com/information).
- When you check your rate and review loan offers, a soft inquiry will be performed on your credit report, which won't impact your credit score. Soft inquiries can only be seen by you. When you accept a loan offer and submit it for review, a hard inquiry will be performed, which may impact your credit score and can be viewed by third parties.

Signature: _____ **Date**:_____

Acknowledgement of receipt of notice of privacy practices

Patient name_____ Date of Birth_____

I acknowledge that I have reviewed the Notice of Privacy Practices of Back to Health Physicians Group, Ltd. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of the Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please Initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering system or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question regarding my rights, I may speak with the Privacy Officer about my concerns.

Patient (Guardian) Signature_____ Date_____

Male Patient Questionnaire & History

Name: _____Today's Date: _____
(Last) (First) (Middle)

Date of Birth:_____Age:_____Weight:_____Occupation:_____

SS#: _____Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) I have used steroids in the past for athletic purposes.

Habits:

( ) I smoke cigarettes or cigars _____ a day.
( ) I drink alcoholic beverages _____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine _____ a day.

Personal History

Which conditions are you **currently** experiencing problems with? (Check all that apply)

( ) HIV/AIDS
( ) Alcoholism
( ) Anorexia
( ) Appendicitis
( ) Arthritis
( ) Bronchitis
( ) Bleeding Disorder
( ) Autoimmune problems
( ) Cancer
( ) Depression/anxiety
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fractures
( ) Heart Disease
( ) Hernia
( ) Herniated disc
( ) Miscarriage
( ) High Cholesterol
( ) Multiple Sclerosis
( ) Osteoporosis
( ) Pacemaker
( ) Parkinson's
( ) Pinch Nerve
( ) Pneumonia
( ) Polio
( ) Prostate Problems
( ) Stroke
( ) Rheumatoid Arthritis
( ) Suicide Attempt
( ) Thyroid Problems
( ) Tumor growth
( ) Ulcers
( ) Vaginal infections
( ) Whiplash
( ) Bulimia
( ) Constipation
( ) Diarrhea
( ) Hepatitis
( ) Venereal Disease
( ) Asthma
( ) numbness/tingling
( ) Blood clots
( ) Varicose veins
( ) Muscle/joint pain
( ) high/low blood pressure
( ) Chronic headaches/migraines
( ) Sprains/strains
( ) None

****If you have experienced problems with any of the above condition(s) in the **past, please circle the condition.**

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes please explain: _____

Medications Currently Taking: _____

Dosage:_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

Activity Level: ( ) Low ( ) Moderate ( ) Medium-High ( ) High
Other: ( ) On 5a Reductase. ( ) Urological work-up performed and ok.

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): _____
Year: _____

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease. Medication:_____
( ) Arthritis. Dose:_____

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

_____ _____ _____
Print Name **Signature** **Today's Date**

Organic Complaints:

( ) Eyes
( ) Ears
( ) Sinuses
( ) Nose
( ) Tonsils
( ) Throat
( ) Lungs
( ) Heart
( ) Chest
( ) Liver
( ) Kidneys
( ) Pancreas
( ) Spleen
( ) Stomach
( ) Bowels
( ) Bladder
( ) Penis
( ) Prostate
( ) Testicles
( ) Vagina
( ) Ovaries
( ) Rectum
( ) None

Family History:

( ) HIV/AIDS
( ) Anemia
( ) Appendicitis
( ) Autoimmune problems
( ) Bleeding Disorder
( ) Cancer
( ) Depression
( ) Emphysema
( ) Fractures
( ) Hernia
( ) High Cholesterol
( ) Multiple Sclerosis
( ) Pacemaker
( ) Pinch Nerve
( ) Polio
( ) Rheumatoid Arthritis
( ) Suicide Attempt
( ) Tumor growth
( ) Vaginal infections
( ) Venereal Disease
( ) Alcoholism
( ) Anorexia
( ) Arthritis
( ) Bronchitis
( ) Bulimia
( ) Chemical dependency
( ) Diabetes
( ) Epilepsy
( ) Heart Disease
( ) Herniated Disc
( ) Miscarriage
( ) Osteoporosis
( ) Parkinson's
( ) Pneumonia
( ) Prostate Problems
( ) Stroke
( ) Thyroid Problems
( ) Ulcers
( ) Whiplash
( ) None

**I attest that all the information completed on the following forms is true and correct.*

Patient Signature:_____ Date:_____

RECORD RELEASE AUTHORIZATION

(If you would like our office to request your records from another Doctor and/or Facility, fill out the FROM section)

FROM:

Doctor/Facility/Hospital Name: _____

Address: _____

Phone: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

Back To Health Physician's Group, 25 West Lincoln Ave, Charleston, IL 61920

(If you would like our office to release records to another person/entity such as spouse, significant other, parent, other family member, lawyer, etc., fill out the TO section)

TO:

Person/Entity: _____

Address: _____

Phone: _____

Person/Entity: _____

Address: _____

Phone: _____

_____ _____

Patient's Signature Date

_____

Patient's Name (Please Print)

_____ _____

Parent/Guardian Signature (If patient under 18 yrs. old) Relationship To Patient

_____ _____

Witness To The Above Signatures Please Print Name

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on, _____, by the licensed doctors of chiropractic, medical professionals, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgements based upon facts and information known to the doctor. The doctor uses this judgement to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgement. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment, based upon facts known, that is in my best interests.

I further understand that there are certain degrees of risks associated with chiropractic health care and physical therapy, which include rarely, but not limited to, fractures, disc injuries, strokes, and strains/sprains and therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

By my signature on this form I do hereby state to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time.

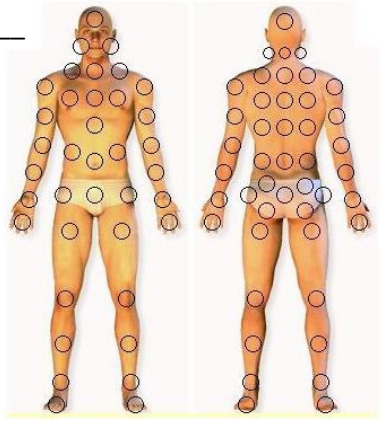
Date of last menstruation (if applicable): _____

_____	_____
Patient's Name (Print)	Patient's Signature
_____	_____
Date	Relationship or authority if not signed by patient
_____	_____
Witness (Print)	Witness Signature

Patient Name:_____ Date:_____

Primary (Main) Complaint: _____

Mark the region of your discomfort (mark the dots)



How would you rate the level of discomfort right now on a scale of 10? (Circle one)

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling? (Circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? (Circle one)

1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? (Circle one)

1 2 3 4 5 6 7 8 9 10

Is the onset of the discomfort gradual or sudden? (Circle one)

Gradual Sudden

When did the discomfort begin? (Fill in a number on the blank line)

___hour(s) ago ___day(s) ago ___week(s) ago ___month(s) ago ___year(s) ago

Since the problem began have the symptoms been getting better, worse or relatively unchanged? (Circle one)

Better Worse Unchanged

What aggravates the discomfort? (Check all that apply)

__ Bending	__Bowling	__Carrying	__Cleaning	__Climbing	__Cooking	__Coughing
__Crawling	__Cycling	__Dressing	__Driving	__Eating	__Exercising	__Gardening
__Jumping	__Kneeling	__Lifting	__Lying	__Medications	__Golf	__Tennis
__Pulling	__Pushing	__Reaching	__Resting	__Running	__Sex	__Sitting
__Sleeping	__Sliding	__Sneezing	__Standing	__Stooping	__Swinging	__Turning
__Twisting	__Typing	__Walking	__Working	__ Nothing		

Patient Name:_____ Date:_____

What percentage worse is the discomfort after it is aggravated?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way? _____minutes

What relieves the discomfort? (Check all that apply)

__ Bending	__Bowling	__Carrying	__Cleaning	__Climbing	__Cooking	__Coughing
__Crawling	__Cycling	__Dressing	__Driving	__Eating	__Exercising	__Gardening
__Jumping	__Kneeling	__Lifting	__Lying	__Medications	__Golf	__Tennis
__Pulling	__Pushing	__Reaching	__Resting	__Running	__Sex	__Sitting
__Sleeping	__Sliding	__Sneezing	__Standing	__Stooping	__Swinging	__Turning
__Twisting	__Typing	__Walking	__Working	__ Nothing		

What percentage would you say the discomfort improves? _____%

What is the quality of the discomfort? (Check all that apply)

__Aching	__Anguish	__Burning	__Continuous	__Deep	__Depression	__Despair
__Discomfort	__Dull	__Frequent	__Insidious	__Intense	__Intermittent	__Malaise
__Melancholy	__Mild	__Moderate	__Numb	__Numbness	__Occasional	__Pain
__Random	__Severe	__Self Loathing	__Sharp	__Shooting	__Superficial	__Throbbing
__Tingling	__Tightness					

When is the discomfort at its worst? (Circle one)

In the morning In the afternoon In the evening Just before bed

Does the pain radiate up or down? (Circle one)

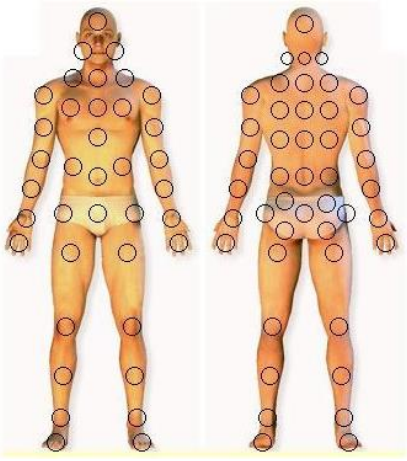
Upward Downward In all directions Does Not Radiate

Where does the pain radiate? (Circle all that apply)

Right arm Left arm Right leg Left leg Neck Spine Other:_____

Patient Name:_____ Date:_____

Second Complaint: _____
Where is your discomfort?



How would you rate the level of discomfort right now on a scale of 10? (Circle one)

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling? (Circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? (Circle one)

1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? (Circle one)

1 2 3 4 5 6 7 8 9 10

Is the onset of the discomfort gradual or sudden? (Circle one)

Gradual Sudden

When did the discomfort begin? (Fill in a number on the blank line)

___hour(s) ago ___day(s) ago ___week(s) ago ___month(s) ago ___year(s) ago

Since the problem began have the symptoms been getting better, worse or relatively unchanged? (Circle one)

Better Worse Unchanged

What aggravates the discomfort? (Check all that apply)

__ Bending	__Bowling	__Carrying	__Cleaning	__Climbing	__Cooking	__Coughing
__Crawling	__Cycling	__Dressing	__Driving	__Eating	__Exercising	__Gardening
__Jumping	__Kneeling	__Lifting	__Lying	__Medications	__Golf	__Tennis
__Pulling	__Pushing	__Reaching	__Resting	__Running	__Sex	__Sitting
__Sleeping	__Sliding	__Sneezing	__Standing	__Stooping	__Swinging	__Turning
__Twisting	__Typing	__Walking	__Working			

Patient Name:_____ Date:_____

What percentage worse is the discomfort after it is aggravated?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way? _____minutes

What relieves the discomfort? (Check all that apply)

__ Bending	__Bowling	__Carrying	__Cleaning	__Climbing	__Cooking	__Coughing
__Crawling	__Cycling	__Dressing	__Driving	__Eating	__Exercising	__Gardening
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__Sleeping	__Sliding	__Sneezing	__Standing	__Stooping	__Swinging	__Turning
__Twisting	__Typing	__Walking	__Working	__ Nothing		

What percentage would you say the discomfort improves? _____%

What is the quality of the discomfort? (Check all that apply)

__Aching	__Anguish	__Burning	__Continuous	__Deep	__Depression	__Despair
__Discomfort	__Dull	__Frequent	__Insidious	__Intense	__Intermittent	__Malaise
__Melancholy	__Mild	__Moderate	__Numb	__Numbness	__Occasional	__Pain
__Random	__Severe	__Self Loathing	__Sharp	__Shooting	__Superficial	__Throbbing
__Tingling	__Tightness					

When is the discomfort at its worst? (Circle one)

In the morning In the afternoon In the evening Just before bed

Does the pain radiate up or down? (Circle one)

Upward Downward In all directions

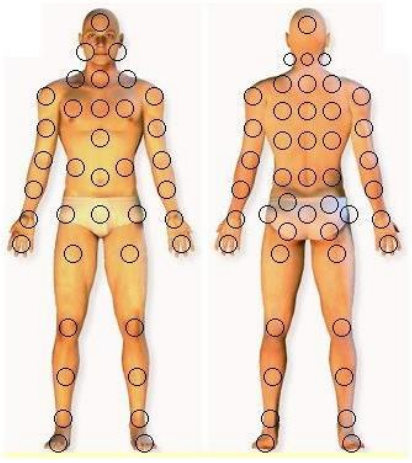
Where does the pain radiate? (Circle all that apply)

Right arm Left arm Right leg Left leg Neck Spine

Patient Name:_____ Date:_____

Third Complaint: _____

Where is your discomfort?



How would you rate the level of discomfort right now on a scale of 10? (Circle one)

1 2 3 4 5 6 7 8 9 10

What is the frequency of the discomfort you are feeling? (Circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How bad is the discomfort at its worst? (Circle one)

1 2 3 4 5 6 7 8 9 10

How would you rate the discomfort at its best? (Circle one)

1 2 3 4 5 6 7 8 9 10

Is the onset of the discomfort gradual or sudden? (Circle one)

Gradual Sudden

When did the discomfort begin? (Fill in a number on the blank line)

___hour(s) ago ___day(s) ago ___week(s) ago ___month(s) ago ___year(s) ago

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Better Worse Unchanged

What aggravates the discomfort? (Check all that apply)

__ Bending	__Bowling	__Carrying	__Cleaning	__Climbing	__Cooking	__Coughing
__Crawling	__Cycling	__Dressing	__Driving	__Eating	__Exercising	__Gardening
__Jumping	__Kneeling	__Lifting	__Lying	__Medications	__Golf	__Tennis
__Pulling	__Pushing	__Reaching	__Resting	__Running	__Sex	__Sitting
__Sleeping	__Sliding	__Sneezing	__Standing	__Stooping	__Swinging	__Turning
__Twisting	__Typing	__Walking	__Working			

Patient Name:_____ Date:_____

What percentage worse is the discomfort after it is aggravated?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How many minutes will the discomfort remain that way? _____minutes

What relieves the discomfort? (Check all that apply)

__ Bending	__Bowling	__Carrying	__Cleaning	__Climbing	__Cooking	__Coughing
__Crawling	__Cycling	__Dressing	__Driving	__Eating	__Exercising	__Gardening
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__Pulling	__Pushing	__Reaching	__Resting	__Running	__Sex	__Sitting
__Sleeping	__Sliding	__Sneezing	__Standing	__Stooping	__Swinging	__Turning
__Twisting	__Typing	__Walking	__Working			

What percentage would you say the discomfort improves? _____%

What is the quality of the discomfort? (Check all that apply)

__Aching	__Anguish	__Burning	__Continuous	__Deep	__Depression	__Despair
__Discomfort	__Dull	__Frequent	__Insidious	__Intense	__Intermittent	__Malaise
__Melancholy	__Mild	__Moderate	__Numb	__Numbness	__Occasional	__Pain
__Random	__Severe	__Self Loathing	__Sharp	__Shooting	__Superficial	__Throbbing
__Tingling	__Tightness					

When is the discomfort at its worst? (Circle one)

In the morning In the afternoon In the evening Just before bed

Does the pain radiate up or down? (Circle one)

Upward Downward In all directions

Where does the pain radiate? (Circle all that apply)

Right arm Left arm Right leg Left leg Neck Spine