- Chandler - 1949 W. Ray Road #23, Chandler, AZ 85224 Ph: (480) 917-1720
- Mesa - 5233 E. Southern Ave. #104, Mesa, AZ 85206 Ph: (480) 830-2882
- Gilbert - 754 S. Val Vista Drive #105, Gilbert, AZ 85296 Ph: (480) 497-2900
- Phoenix - 2836 E. Indian School Rd. #A8, Phoenix, AZ 85016 Ph: (602) 840-0056
- Tempe - 1855 E. Guadalupe Rd. #112, Tempe, AZ 85283 Ph: (480) 839-8552
- Queen Creek - 21323 S. Ellsworth Loop Rd. #101, Queen Creek, AZ 85142 Ph: (480) 307-8440
- Ocotillo - 2815 E. Ocotillo Rd. #4, Chandler, AZ 85249 Ph: (480) 781-2964
- Desert Ridge - 21001 N. Tatum Blvd. #78-1640, Phoenix, AZ 85050 Ph: (480) 306-7832
- Goodyear - 3301 N. Litchfield Road #200, Goodyear, AZ 85395 Ph: (623) 935-2929d
- Surprise – 13733 N. Prasada Parkway Ste #100, Surprise, AZ 85388 PH: (623) 444-7100

BACKFIT HEALTH SPINE

Name_____ **Nickname**_____ **How did you hear about us**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Cell Phone_____ **Home Phone** _____ **SSN**_____

Home Email_____ **Date of Birth**_____ **Age**_____ **Gender** ❑ Male ❑ Female ❑ Unspecified

Emergency Contact_____ **Contact Phone #**_____

Marital Status ❑ Single ❑ Married ❑ Other **Children** ❑ Yes ❑ No How Many?_____

Employment Status ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____ **Employer**_____ **Employer Phone** _____

Do you have insurance? ❑ Yes ❑ No **Insurance Name**_____

Primary insured?❑ Yes ❑ No **If no, primary insured name and relationship to self**_____ **Their DOB**_____

Family Physician_____ **Phone** _____

Current medications, COMPLETE FULLY:

RX Medication/Over The Counter	Dosage
1)	
2)	
3)	
4)	
5)	

Known Medical Conditions:

1) _____
2) _____
3) _____
4) _____
5) _____

List any known allergies you have had to any medications, foods or environment:

1) _____ 3) _____

2) _____ 4) _____

Do you suffer from seasonal allergies? ❑ Yes ❑ No If Yes, have you had allergy testing before? ❑ Yes ❑ No
Do you suffer from food sensitivity? ❑ Yes ❑ No If Yes, have you had food sensitivity testing before? ❑ Yes ❑ No

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. **(P) for Patient or (F) for family

❑ Alcoholism	**(P or F)**	❑ High Blood Pressure	**(P or F)**	❑ Stroke	**(P or F)**
❑ Anemia	**(P or F)**	❑ Kidney Disease	**(P or F)**	❑ Suicide Attempt	**(P or F)**
❑ Asthma	**(P or F)**	❑ Liver Disease	**(P or F)**	❑ Thyroid Disease	**(P or F)**
❑ Cancer/Tumor	**(P or F)**	❑ Hepatitis	**(P or F)**	❑ Heart Disease	**(P or F)**
❑ Diabetes	**(P or F)**	❑ Lung Disease	**(P or F)**	❑ Ulcers	**(P or F)**
❑ Drug Abuse	**(P or F)**	❑ Rheumatic Arthritis	**(P or F)**	❑ HIV or Other Immune Disease	**(P or F)**
❑ Depression	**(P or F)**	❑ Osteoarthritis	**(P or F)**	❑ High Cholesterol	**(P or F)**
❑ Epilepsy/Seizures	**(P or F)**	❑ Osteoporosis	**(P or F)**	❑ Other	

Past Health History: Please mark any condition you have now or had in the past

General
❑ Weight Loss
❑ Fatigue
❑ Fever

MSK
❑ Joint Pain
❑ Stiffness
❑ Muscle Pain
❑ Swollen Joints

Psychiatric
❑ Anxiety
❑ Depression

GU
❑ Erectile Dysfunction
❑ Leaky Bladder
❑ Blood in Urine
❑ Frequent Urination
❑ Painful urination

ENT
❑ Difficult Hearing
❑ Ear Ringing
❑ Vertigo
❑ Sinus Trouble
❑ Chronic Sore Throat

Hematology
❑ Easy Bruising
❑ Easy Bleeding

Endocrine
❑ Hair Loss
❑ Weight Gain

Respiratory
❑ Coughing
❑ Asthma
❑ Difficult Breathing

Cardiovascular
❑ Heart Murmur
❑ Chest Pain
❑ Palpitations
❑ Short of Breath
❑ Fainting
❑ Swollen Ankles

Females Only
❑ Abnormal Mammo
❑ Abnormal Pap
Pregnant ❑ Y ❑ N
If so, how far along?_____

GI
❑ Heartburn
❑ Nausea
❑ Constipation
❑ Diarrhea
❑ Abdominal Pain

Eyes
❑ Glasses
❑ Eye Pain
❑ Double Vision

Skin
❑ Rash
❑ Itching
❑ Lesions

Neurological
❑ Strength Loss
❑ Numbness
❑ Tremors
❑ Memory Loss
❑ Headaches
Frequency_____

Patient Signature_____ Date_____ Dr Initials_____

- Chandler - 1949 W. Ray Road #23, Chandler, AZ 85224 Ph: (480) 917-1720
- Mesa - 5233 E. Southern Ave. #104, Mesa, AZ 85206 Ph: (480) 830-2882
- Gilbert - 754 S. Val Vista Drive #105, Gilbert, AZ 85296 Ph: (480) 497-2900
- Phoenix - 2836 E. Indian School Rd. #A8, Phoenix, AZ 85016 Ph: (602) 840-0056
- Tempe - 1855 E. Guadalupe Rd. #112, Tempe, AZ 85283 Ph: (480) 839-8552
- Queen Creek - 21323 S. Ellsworth Loop Rd. #101, Queen Creek, AZ 85142 Ph: (480) 307-8440
- Ocotillo - 2815 E. Ocotillo Rd. #4, Chandler, AZ 85249 Ph: (480) 781-2964
- Desert Ridge - 21001 N. Tatum Blvd. #78-1640, Phoenix, AZ 85050 Ph: (480) 306-7832
- Goodyear - 3301 N. Litchfield Road #200, Goodyear, AZ 85395 Ph: (623) 935-2929d
- Surprise – 13733 N. Prasada Parkway Ste #100, Surprise, AZ 85388 PH: (623) 444-7100

BACK FIT HEALTH SPINE

1st Chief Complaint: _____ When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10)

2nd Chief Complaint :_____ When did it start?_____ Gradual / Sudden

Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10)

3rd Chief Complaint: _____ When did it start?_____ Gradual / Sudden

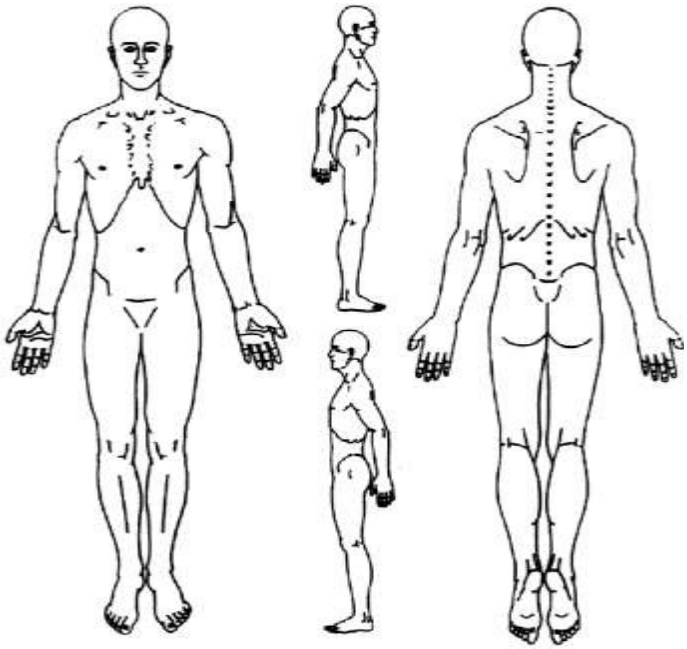
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

Circle the percentage of the day you experience the complaint:
10 20 30 40 50 60 70 80 90 100

How would you rate the pain at its worst? (1 – 10)

Using the letters below, please show <u>where</u> you are experiencing <u>all</u> of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Have you ever had tests for your present condition? ❑ MRI ❑ X-ray ❑ CT ❑ Other_____ Do you have a pa

Do you drink alcohol? ❑ Yes ❑ No If Yes, what is frequency_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke?

When was your last Physical Examination?_____ When did you last have blood work? ❑ Within a Year

Any Surgeries? ❑ Yes ❑No If yes, list:

Patient Name (please print)

Patient Signature_____Date_____ Dr. Initials