THE BACK ALLEY
CHIROPRACTIC & MASSAGE

PATIENT UPDATE

Please take the time to complete these forms to the best of your ability. If you have any questions, we will be glad to help you.

First Name _____ **Middle** Initial _____ **Last** Name _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (*if different*) _____

City _____ State _____ Zip Code _____

Email Address* _____

*Providing an email is explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details)

Cell Phone _____ Would you like to receive text reminders? ☐ Yes ☐ No

Home Phone _____ **Work** Phone _____

Emergency Contact Name _____ Phone # _____

Primary Care Physician _____ Phone # _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employment Status: ☐ Employed _____ ☐ Retired ☐ Not Employed ☐ Student
(employer name)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

COVERAGE INFORMATION

If you are **Self Pay**, please request a copy of our updated fee schedule. If you are **Insured**, please provide your insurance card(s) to reception with your Identification Card. Digital cards should be emailed to thebackalleychiro@yahoo.com.

☐ Self Pay ☐ Health Insurance ☐ Medicare/Medicaid

SYMPTOMS

List and describe your ***chief complaint*** *and answer all questions following. If you need more space, please ask for an additional page.*

Chief complaint _____ How long ago? #____ Days #____ Weeks #____ Months #____ Years

How did this begin? ☐ job related injury ☐ auto accident ☐ illness ☐ injury ☐ unknown ☐ gradual onset ☐ sudden onset

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, or emails as an extension of my care in this office.

Patient or Parent/Guardian Signature _____ Date _____

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