CALL #1 CALL #2 CALL #3 CALL #4 CALL #5

HEALTH SCREENING FORM

HSR
M Tu W Th F Sa
____/____/____
_____AM PM
KEPT: Yes No

RS_____

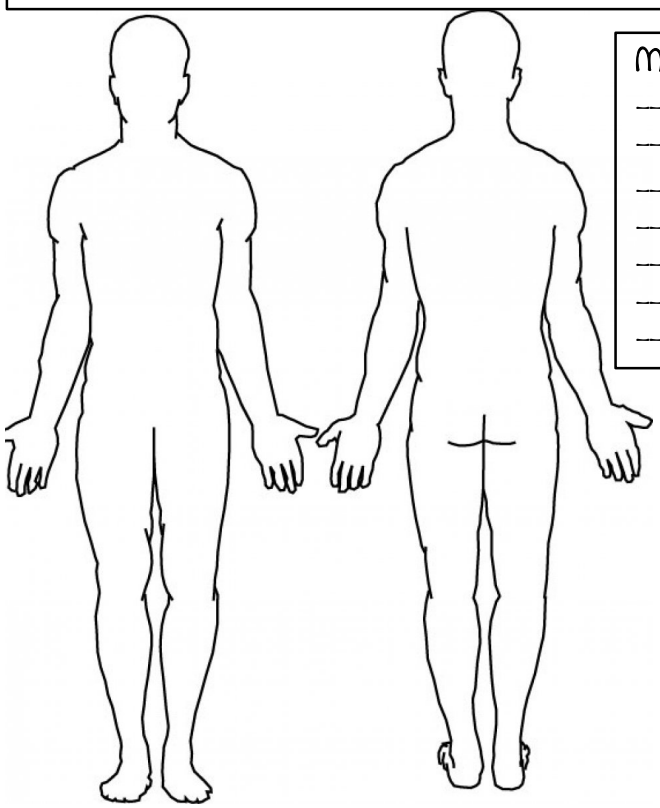
HSR Completed by
_____

Name:_____ Date:_____
Phone Number:_____
Place of Business:_____
Insurance Type:_____
Event/Source:_____

Personal Injury: Yes No Workman's Comp: Yes No
DOB:____/____/____ Sex: MALE FEMALE Married: Yes No

HISTORY/COMPLAINT:_____
_____
_____
_____

How long have you been thinking about having this checked or concerned about what might be causing this pain?_____
_____
_____
_____



MANUAL THERAPY
___Chief Complaint
___Symptoms
___ADL's
___Procrastination
___Trigger Points
___Soreness after MT
___Follow Up

Itemized Screening Services:
___Health Screening
___Manual Therapy
___X-Ray (IF WARRANTED)

Radiology
(if medically necessary, circle one view only)
___Cervical AP LAT
___Thoracic AP LAT
___Lumbar AP LAT
___Other_____
Done by: _____ (Initial)

Therapy Area: _____
___EMS
___Traction
___Interferential
___Massage C T LB
Done by: _____ (Initial)

This is to here by certify that I am aware of the completion of this Health Screening/Massage. I understand that any further services, are not complimentary and will be charged at BackToWellness's regular rates.
Patient Signature:_____
Date:_____
Health Care Provider: Trevor Chalfant D.C.

___Understanding condition/treatment
___Time
___Spouse
___I want to think about it
___ Affordability

Back To Wellness
6825 Parkdale Place Suite C
Indianapolis, Indiana 46254
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Indianapolis, IN 46254
317.536.2892