Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

READ ALL THIS INFORMATION BEFORE YOU BEGIN COMPLETING THESE FORMS

- IF YOU NEED HELP
  - If you need help with this form, complete as much of it as you can and call the office at 317.536.2892.
- HOW TO COMPLETE THIS FORM
  - The information that you give us on this form will be used by the office staff and Dr. Chalfant. You can help us by completing as much of these forms as you can.
  - It is important that you tell us about **ALL** your injury(ies), health history, activities and abilities.
  - Print or type.
  - DO NOT LEAVE ANSWERS BLANK. If you do not know the answer or the answer is "none" or "does not apply," please write "don't know" or "none" or "does not apply."
  - Do not ask BackToWellness staff or Dr. Chalfant to complete these forms for you.
  - Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from helping you.

We rarely use the information you supply for any purpose other than the reason stated above.

Anyone who makes or causes a false statement to be made or representation of material fact for use in the office of BackToWellness, or knowingly conceals or fails to disclose an event with an intent to affect an outcome or care, commits a crime punishable under Federal law by fine, imprisonment, or both, and may be subject to administrative sanctions.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. We estimate that it will take about 35 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO BACKTOWELLNESS. You may send comments on our time estimate above to: 6825 Parkdale Place Suite C, Indianapolis, Indiana 46214 or email us at indianabacktowellness@gmail.com.
Send only comments relating to our time estimate to this address, not the completed form.

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 1 PERSONAL DATA

Patient Name: First_____ Middle_____ Last_____

Prefers to Be Called: _____ Birth Date: ____/____/_____ Sex: ☐Female ☐Male

Parent or Guardian's Name if the Patient is a minor: _____

Are you currently pregnant? ☐YES ☐NO Have you ever been pregnant? ☐YES ☐NO

Where do you live? ☐House ☐Apartment ☐Nursing home ☐ Other_____

Home Address: _____

City: _____, State: _____, Zip: _____

Phone: Home: _____ Work: _____ Mobile: _____

With Whom Do you live? ☐Alone ☐With Family ☐With Friends ☐Other_____

Genetic Background: ☐African ☐European ☐Native American ☐Mediterranean ☐Asian ☐Ashkenazi

Email: _____

Current Employer: _____ Contact Phone: _____

Work Address: _____

City: _____, State: _____, Zip: _____

Job Description: _____

Marital Status: ☐Single ☐Life-Partner ☐Married ☐Divorced ☐Widowed

Spouse/Partner Name: _____ Spouse's Employer: _____

Number of Children: _____ Ages: _____

Emergency Contact Person: _____ Phone: _____

How Did You Hear About BackToWellness:_____

Reason for Visit: Injury or Wellness, if injury where:_____

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 2 REASON FOR CARE

Reason for care: I am here for a specific condition: ☐YES ☐NO
I am here for a nutritional consultation: ☐YES ☐NO

IF NO GO DIRECTLY TO SECTION 3

Primary Complaint	Secondary Complaint	Tertiary Complaint
Briefly describe complaint: _____	Briefly describe complaint: _____	Briefly describe complaint: _____
Did trauma cause the onset of this injury? ☐YES ☐NO **if Yes make sure to add to section 5 as an ACCIDENT***	Did trauma cause the onset of this injury? ☐YES ☐NO **if Yes make sure to add to section 5 as an ACCIDENT***	Did trauma cause the onset of this injury? ☐YES ☐NO **if Yes make sure to add to section 5 as an ACCIDENT***
Date of injury: _____/_____/_____	Date of injury: _____/_____/_____	Date of injury: _____/_____/_____
How did this injury happen: _____ _____	How did this injury happen: _____ _____	How did this injury happen: _____ _____
Does the pain radiate or travel? ☐YES ☐NO	Does the pain radiate or travel? ☐YES ☐NO	Does the pain radiate or travel? ☐YES ☐NO
PAIN SCALE (CIRCLE) Best 0 1 2 3 4 5 6 7 8 9 10 Worst	PAIN SCALE (CIRCLE) Best 0 1 2 3 4 5 6 7 8 9 10 Worst	PAIN SCALE (CIRCLE) Best 0 1 2 3 4 5 6 7 8 9 10 Worst
Is it constant? ☐YES ☐NO	Is it constant? ☐YES ☐NO	Is it constant? ☐YES ☐NO
Comes and goes? ☐YES ☐NO	Comes and goes? ☐YES ☐NO	Comes and goes? ☐YES ☐NO
When are you in pain? ☐Morning ☐Afternoon ☐Evening	When are you in pain? ☐Morning ☐Afternoon ☐Evening	When are you in pain? ☐Morning ☐Afternoon ☐Evening
Please check ALL that describe your current symptoms:	Please check ALL that describe your current symptoms:	Please check ALL that describe your current symptoms:
☐sharp ☐pins & needles	☐sharp ☐pins & needles	☐sharp ☐pins & needles
☐stabbing ☐tingling	☐stabbing ☐tingling	☐stabbing ☐tingling
☐dull ☐numbness	☐dull ☐numbness	☐dull ☐numbness
☐aching ☐tightness	☐aching ☐tightness	☐aching ☐tightness
☐pinching ☐other:_____	☐pinching ☐other:_____	☐pinching ☐other:_____
Please check ALL that aggravate your condition:	Please check ALL that aggravate your condition:	Please check ALL that aggravate your condition:
☐driving ☐breathing	☐driving ☐breathing	☐driving ☐breathing
☐walking ☐coughing	☐walking ☐coughing	☐walking ☐coughing
☐sitting ☐sleeping	☐sitting ☐sleeping	☐sitting ☐sleeping
☐bending ☐working	☐bending ☐working	☐bending ☐working
☐standing ☐exercising	☐standing ☐exercising	☐standing ☐exercising
☐bowel movements ☐other:_____	☐bowel movements ☐other:_____	☐bowel movements ☐other:_____

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 2 REASON FOR CARE CONTINUED

Primary Complaint	Secondary Complaint	Tertiary Complaint
What makes your condition better?	What makes your condition better?	What makes your condition better?
☐Chiropractic ☐stretching ☐rest ☐massage ☐recumbent ☐medication ☐sitting ☐nothing ☐standing ☐other:_____	☐Chiropractic ☐stretching ☐rest ☐massage ☐recumbent ☐medication ☐sitting ☐nothing ☐standing ☐other:_____	☐Chiropractic ☐stretching ☐rest ☐massage ☐recumbent ☐medication ☐sitting ☐nothing ☐standing ☐other:_____
Have you had this complaint in the past? ☐YES ☐NO If yes, when? _____/_____/_____	Have you had this complaint in the past? ☐YES ☐NO If yes, when? _____/_____/_____	Have you had this complaint in the past? ☐YES ☐NO If yes, when? _____/_____/_____
Have you seen any other healthcare providers for your complaint? ☐YES ☐NO Name:_____ Profession:_____	Have you seen any other healthcare providers for your complaint? ☐YES ☐NO Name:_____ Profession:_____	Have you seen any other healthcare providers for your complaint? ☐YES ☐NO Name:_____ Profession:_____

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 3 HEALTH HABITS & LIFESTYLE

Please answer the questions below.

EXERCISE

Do you exercise? ☐YES ☐NO

How often do you exercise?

_____days/week _____hours/day

Stretching/Flexibility ☐YES ☐NO

Running ☐YES ☐NO

Treadmill ☐YES ☐NO

Walking ☐YES ☐NO

Biking ☐YES ☐NO

Cycling ☐YES ☐NO

Rowing ☐YES ☐NO

Swimming ☐YES ☐NO

Pilates/Yoga ☐YES ☐NO

Group Exercise ☐YES ☐NO

Weight Lifting ☐YES ☐NO

HIIT Training ☐YES ☐NO

CrossFit ☐YES ☐NO

Other: (PLEASE LIST)

_____

_____

_____

DIET

Do you have a healthy diet?
☐YES ☐NO

How many servings of fruit per day? _____

(1 portion/serving = tennis ball)

How many servings of vegetables per day? _____

(1 portion/serving = tennis ball)

How many 8oz. Glasses of water per day? _____

Do you drink caffeinated beverages?
☐YES ☐NO

How many per day? _____

Please List Food Allergies:

_____

_____

_____

Have you ever had an eating disorder? ☐YES ☐NO

_____

_____

_____

DAILY STRESS LEVEL SCALE

LOW HIGH

0 1 2 3 4 5 6 7 8 9 10

Have you ever sought help for a mental health issue? ☐YES ☐NO

ALCOHOL/TOBACCO/ RECREATIONAL DRUG USE

Do you use any of the above?

☐YES ☐NO

How many cigarettes do you smoke?

_____/day or _____/week

Do you use smokeless tobacco?
☐YES ☐NO

How much do you use per day?

Can or pouches (circle one) _____/day

Do you have a history of alcohol use? ☐YES ☐NO

drinks _____/day or _____/week

1 "drink" is equal to 12 oz. can of beer, 1½ oz. liquor - 80 proof, or 5 oz. wine

SLEEPING PATTERN

Hours of sleep per night? _____ hours

Please circle appropriate sleep quality.

Excellent Good Fair Poor

Sleep interrupted _____x's per night

How long? _____ weeks, _____ months, _____ years

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 4 PERSONAL HEALTH HISTORY

Please mark all issues below that you currently or have had in the past.

C = Current P = Past ☐ = Not Applicable

MUSCLE/JOINT	C	P	☐	**INTERNAL**	C	P	☐	**URINARY**	C	P	☐
Arthritis	C	P	☐	Liver	C	P	☐	Kidney	C	P	☐
Back Pain	C	P	☐	Gall bladder	C	P	☐	Difficulty originating	C	P	☐
Sciatic Pain	C	P	☐	Pancreas	C	P	☐	**REPRODUCTIVE**	C	P	☐
Bursitis	C	P	☐	**SKIN**	C	P	☐	Menstrual	C	P	☐
Hip Pain	C	P	☐	Easy bruising	C	P	☐	Pregnancy	C	P	☐
Foot Pain	C	P	☐	Psoriasis/Eczema	C	P	☐	Prostate	C	P	☐
Neck Pain	C	P	☐	Hives	C	P	☐	Venereal Disease	C	P	☐
Headache	C	P	☐	Skin Allergy	C	P	☐	**GENERAL**	C	P	☐
Shoulder Pain	C	P	☐	Itching	C	P	☐	Food Allergy	C	P	☐
Arm Pain	C	P	☐	Varicose	C	P	☐	Dizziness	C	P	☐
Wrist Pain	C	P	☐	**PULMONARY**	C	P	☐	Infections	C	P	☐
EYES/EARS/THROAT	C	P	☐	Difficulty breathing	C	P	☐	**INFECTIOUS DISEASES**	C	P	☐
Thyroid	C	P	☐	COPD	C	P	☐	HIV	C	P	☐
Hearing Difficulty	C	P	☐	Asthma	C	P	☐	Hepatitis	C	P	☐
Vision	C	P	☐	Seasonal Allergy	C	P	☐	Tuberculosis	C	P	☐
DIGESTIVE	C	P	☐	**CARDIOVASCULAR**	C	P	☐	**ENDOCRINE**	C	P	☐
Stomach	C	P	☐	Blood Pressure	C	P	☐	**NEUROLOGICAL**	C	P	☐
Intestinal	C	P	☐	Irregular Heart Beat	C	P	☐	**PHYSIOLOGICAL**	C	P	☐
Colon	C	P	☐	Poor Circulation	C	P	☐				

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 4 PERSONAL HEALTH HISTORY CONTINUED

Please list ALL the medications you are taking including over the counter medications, herbs, vitamins, and nutritional supplements. If none please write NONE.

Example:

Name: Vitamin C Dose: 100mg Frequency: 6x per day

Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____

	now	PAST		now	PAST
Aspirin			Antibiotics		
Tylenol			Antihistamine		
decongestant			Other:_____		
Ibuprofen			Other:_____		

Medication Allergies: Please List all below _____
_____
_____
_____

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 5 ACCIDENTS, INJURIES, SURGERIES, & HOSPITALIZATIONS

Please list ALL accidents, injuries, surgeries, & hospitalizations. If none please write NONE.

TYPE	PROCEDURE DONE/DESCRIPTION	DATE DONE
EX: back surgery	Fusion L2	01/01/2011
EX: hospital stay	Child birth - c section/home birth/unassisted	01/01/2011
EX: accident	Fell downstairs	01/01/2011
EX: car accident	Rear ended - stopped and hit from behind	01/01/2011
OTHER EXAMPLES ARE appendix, ears (tubes), eyes, feet, joint, tonsils, wisdom teeth etc.		

I HAVE BEEN INVOLVED IN A CAR ACCIDENT ☐YES ☐NO

IF YES PLEASE ADD TO THE ABOVE TABLE

DATE: _____/_____/_____ PATIENT SIGNATURE: _____

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Please list all your doctors and healthcare providers:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Section 6 FAMILY HISTORY

Please mark the appropriate boxes with an "X". If none of the below please check this box ☐.

HISTORY	Diabetes	Heart Problems	High Blood Pressure	High Cholesterol	Kidney Problems	Cancer	Headaches	Anemia	Arthritis	Auto Immune Disorder	Obesity	Deceased	Age at Death	Other:_____	Other:_____	Other:_____
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
FATHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
SIBLING 1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
SIBLING 2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
GRANDMOTHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐
GRANDFATHER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

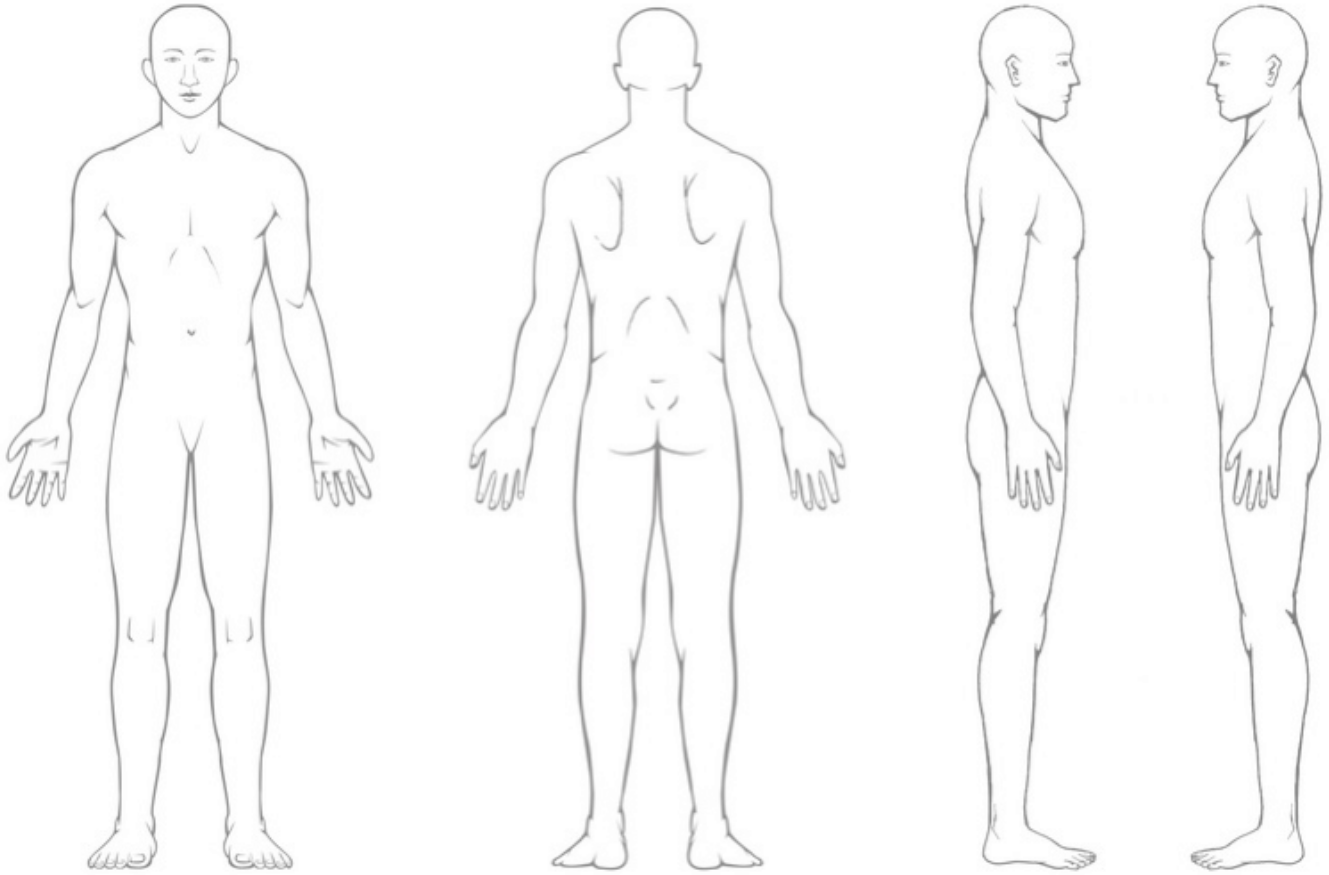
Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 7 INJURY/DISCOMFORT CHART

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	0000000000	^^^^^^^^^^	XXXXXXX	⊗⊗⊗⊗⊗⊗



Please use the space below to describe you condition further if needed: _____
_____
_____.

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 8 Review of Symptoms

The following list of conditions may seem unrelated to your current health problem. However, these problems may influence your overall diagnosis, treatment plan, and whether your case is accepted in this office.

DISEASES - Please circle C=Current or P=Past OR mark an "X" in ☐ for none.

C P ☐ Alcoholism
C P ☐ Anemia
C P ☐ Anorexia
C P ☐ Appendicitis
C P ☐ Arthritis
C P ☐ Asthma
C P ☐ Cancer
C P ☐ Cataracts
C P ☐ Chicken Pox
C P ☐ Diabetes
C P ☐ Diphtheria
C P ☐ Eczema
C P ☐ Epilepsy
C P ☐ Emphysema
C P ☐ Fractures
C P ☐ Headaches
C P ☐ Glaucoma
C P ☐ Goiter
C P ☐ Gout
C P ☐ Heart Disease
C P ☐ Hepatitis
C P ☐ Herniated Disk
C P ☐ Influenza
C P ☐ Kidney Disease
C P ☐ Liver Disease
C P ☐ Lumbago
C P ☐ Malaria
C P ☐ Measles
C P ☐ Mental Disorder
C P ☐ Migraines
C P ☐ Mumps
C P ☐ Osteoporosis
C P ☐ Pleurisy
C P ☐ Pneumonia
C P ☐ Polio
C P ☐ Psychiatric Care
C P ☐ Rheumatic Fever
C P ☐ Scarlett Fever
C P ☐ Small Pox
C P ☐ Stroke
C P ☐ Suicide Attempt
C P ☐ Tonsillitis
C P ☐ Tuberculosis
C P ☐ Tumors
C P ☐ Typhoid Fever
C P ☐ Ulcers
C P ☐ Venereal Infection
C P ☐ Whooping Cough
C P ☐ Rubella

HEALTH PROBLEMS - please circle C=current or P=past OR mark an "X" in ☐ for none.

MUSCUO-SKELETAL

C P ☐ Low Back Pain
C P ☐ Pain Between Shoulders
C P ☐ Neck Pain
C P ☐ Arm Pain
C P ☐ Joint Pain
C P ☐ Stiffness
C P ☐ Walking Problems
C P ☐ Difficult Chewing
C P ☐ Clicking Jaw

NERVOUS SYSTEM

C P ☐ Numbness
C P ☐ Paralysis
C P ☐ Dizziness
C P ☐ Forgetfulness
C P ☐ Confusion
C P ☐ Depression
C P ☐ Fainting
C P ☐ Convulsions
C P ☐ Cold Extremities
C P ☐ Tingly Extremities

GENERAL

C P ☐ Allergies
C P ☐ Loss of Sleep
C P ☐ Fever
C P ☐ Headaches

GENITO-URINARY

C P ☐ Bladder Trouble
C P ☐ Painful/Excess Urination
C P ☐ Discolored Urine

HEALTH PROBLEMS CONTINUED - Please circle C=current or P=past OR mark an "X" in ☐ for none.

GASTRO-INTESTINAL

C P ☐ Poor/Excessive Appetite
C P ☐ Excessive Thirst
C P ☐ Frequent Nausea
C P ☐ Vomiting
C P ☐ Diarrhea
C P ☐ Constipation
C P ☐ Hemorrhoids
C P ☐ Liver Trouble
C P ☐ Gall Bladder Trouble
C P ☐ Weight Gain
C P ☐ Weight Loss
C P ☐ Abdominal Pain
C P ☐ Gas/Bloating After Meals
C P ☐ Heart Burn
C P ☐ Black/Bloody Stools
C P ☐ Colitis

CARDO/RESPIRATORY

C P ☐ Chest Pain
C P ☐ Shortness of Breath
C P ☐ Blood Pressure Problems
C P ☐ Irregular Heart Beat
C P ☐ Lung Problem/Congestion
C P ☐ Varicose Veins
C P ☐ Ankle Swelling

EENT

C P ☐ Vision Problems
C P ☐ Dental Problems
C P ☐ Sore Throat
C P ☐ Ear Aches/Infections
C P ☐ Hearing Difficulty
C P ☐ Stuffed Nose

MALE/FEMALE

C P ☐ Prostate Dysfunction M
C P ☐ Genital Herpes
C P ☐ Breast Pain or Lumps
C P ☐ Menstrual Irregularity F
C P ☐ Menstrual Cramping F
C P ☐ Vaginal Pain/Infections F

_____ ____/____/____
INITIALS MM/DD/YY

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Back To Wellness

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

Section 9 Activities of Daily Living

1. How does your illness(es), injury(jes), or condition(s) limit these areas of daily living:
   a. **Basic communication skills** – such as using a phone, texting, email, written letters
   _____
   b. **Transportation** – Driving oneself, arranging rides or the ability to use public transportation
   _____
   c. **Meal preparation** - Meal planning, preparation, storage and the ability to safely use kitchen equipment
   _____
   d. **Shopping** – The ability to get to the store or make appropriate food and clothing purchase decisions
   _____
   e. **Housework** – Doing laundry, cleaning dishes and maintaining a hygienic place of residence
   _____
   f. **Managing medications** – taking accurate dosages at the appropriate times, managing re fills
   _____
   g. **Managing personal finances** – Operating within a budget, writing checks, paying bills
   _____
   h. **Personal care** – Getting dressed, bathing, hair care, using the toilet
   _____
   i. **Chores** – Inability to perform yardwork or other duties at home
   _____
   j. **Sleep** – Does your injury or illness effect your sleep, if so how?
   _____
   k. **Work** – Does your injury or illness effect your ability to perform your work duties?
   _____
   l. What were you able to do before your illness, injury or condition that you are unable to do now?
   _____
   m. Do you use any of the following? (Check all that apply.) ☐YES ☐NO

☐Crutches	☐Brace/Splint
☐Walker	☐Artificial Limb
☐Wheelchair	☐Hearing Aid
☐Other (Explain)_____	☐Glasses/Contact Lenses
☐Cane	☐Artificial Voice Box

Which of these were prescribed by a doctor?_____
When was it prescribed?_____/_____/_____
When do you need to use these aids?_____

Trevor Chalfant D.C.
indianabacktowellness@gmail.com

Dr. Trevor Lee Chalfant
6825 Parkdale Place Suite C
Indianapolis, IN 46254
P 317.536.2892 F 317.536.4764

I HAVE FILLED THIS PAPERWORK OUT TO THE BEST OF MY ABILTLY AND TRUTHFULLY. ANY INFORMATION I HAVE FAILED TO PUT ON THIS PAPERWORK MAY RESULT IN MISDIAGNOSIS I CANNOT HOLD BACKTOWELLNESS LLC. ACCOUNTABLE GIVEN MY LACK OF HONESTY ON GIVEN PAPERWORK AND HEALTH HISTORY.

PLEASE CHECK YOUR PAPERWORK BEFORE SIGNING.
LEAVE NOTHING BLANK

DATE: _____ PATIENT SIGNATURE: _____

Consent for Chiropractic Care at BackToWellness LLC.

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal adjustments, the goal of chiropractic is primarly to reduce and/or correct spinal subluxations.

- The chiropratic assesment and chiropratic provided in the BackToWellness LLC. Clinic will occur in an open enviroment.
- In some situations, your care will occur in an open enviroment and personal health infomration (PHI) may be subject to incidental exposure by others in the clinical setting.
- I understand that my records and/or x-rays are the property of BackToWellness LLC. And will be used for teaching research purposes and if at anytime I request a copy of my records and/or x-rays there will be an additonal fee for copying them.
- I authorize BackToWellness LLC. and its agents to adminster care as needed, as indiciated from examination findings.
- I authorize BackToWellness LLC. to release information to my doctor and/or insurance company.
- I acknowledge that I have read BackToWellness LLC.'s Notice of Privacy Practices (or had the opportunity to read it if I so choose). I have received a summary of BackToWellness LLC.'s Notice of Privacy Practices and acknowledge that I may have apersonal copy of the entire notice upon request.
- I consent to the use and/or disclosure of my protected health information as specified in BackToWellness's LLC. Notice of Privacy Practices.

I have read and understand the above.

Patient Signature:_____ Date: _____
Guardian Signature: _____ Date: _____
BackToWellness Staff Signature: _____ Date: _____

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyles and habits.

Trevor Chalfant D.C.
indianabacktowellness@gmail.com