Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

Patient Information

(*Our goal is our patient's care and satisfaction; please complete this form in its entirety, were applicable.*)

Name_____

Date_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Status: ☐ Single ☐ Married ☐ Other

Work Phone (_____)_____

Cell phone (_____)_____

Date of Birth_____ Age_____ □ Male □ Female

Email_____ (we send receipts electronically please provide)

Occupation_____Employer_____

Name of Emergency Contact_____

Emergency Contact Telephone#_____

Have you ever received Chiropractic Care? □ Yes □ No

Referred to this office by: □ Friend/Family Member - Name?_____

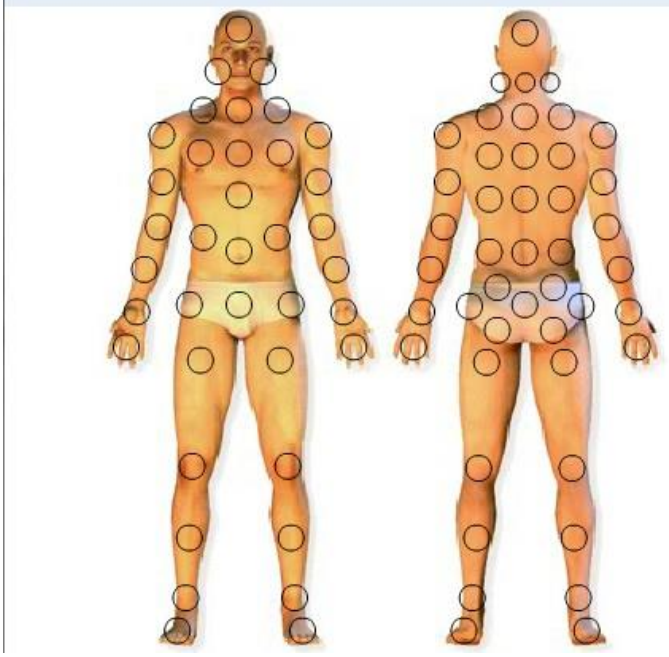
□ Internet_____ □Other_____

Are you covered by more than one insurance company? ____Yes ____ No

Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

Where is Chief Complaint? ?



Using the symbols below, Fill in the circles on the pictures where you feel pain with the below symbols

Description	Symbols
Numbness	=
Dull Ache	●
Burning	X
Sharp/Stabbing	/
Pins, Needles	+ + +
Other _____	^ ^ ^

Symptoms and Present State of Health

Present Complaint/Reason for Seeking Care in this Office:

Primary complaint_____

Pain or Problem started on_____

Reason of Injury/Complaint: _____

Healthcare practitioner seen for this condition_____

Please Describe Your Present Conditions (List Each Body Part Separately 1-4)

1. Body Area_____ (example: low back, neck, headache)
   Does it radiate and if so where to: _____
   Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
   Constant Frequent Intermittent On and off Random

2. Body Area_____ (example: low back, neck, headache)
   Does it radiate and if so where to: _____
   Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
   Constant Frequent Intermittent On and off Random

3. Body Area_____ (example: low back, neck, headache)
   Does it radiate and if so where to: _____
   Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
   Constant Frequent Intermittent On and off Random

4. Body Area_____ (example: low back, neck, headache)
   Does it radiate and if so where to: _____
   Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
   Constant Frequent Intermittent On and off Random

Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

☐Chiropractic Care (adjustments) ☐Cold/Ice pack ☐Exercise ☐Heat packs ☐Massage ☐Nothing
☐Over the counter medication ☐Physical Therapy ☐Prescription medication ☐Rest ☐Stretching ☐Work ☐Walking
☐Other_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

☐Almost any movement ☐Bathing ☐Bending ☐Caring for family ☐Carrying ☐changing positions ☐Climbing Stairs
☐Computer Use ☐Concentrating ☐Cooking ☐Coughing ☐Sneezing ☐Daily child care ☐Daily pet care ☐Driving
☐Eating ☐Falling or Staying asleep ☐Getting in or out of the car ☐Getting out of Bed ☐Getting up from a lying down position
☐Getting up from sitting ☐Grocery Shopping ☐Household Chores ☐Lifting ☐Looking over shoulder ☐Lying down
☐Pulling ☐Pushing ☐Reaching ☐Reading ☐Repetitive Motions ☐Resting ☐Running ☐Sitting ☐Squatting
☐Standing ☐Stress ☐Stretching ☐Talking on the Telephone ☐Turning ☐Twisting ☐Walking ☐Working ☐Yard Work
☐Other_____

Previous episodes of complaint: _____

Previous Care for this complaint: _____

Recent Diagnostic tests: _____

Activity of daily living most affected?

☐Employment ☐Homemaking ☐Lifting ☐Personal Care (washing, dressing, etc.) ☐Sitting ☐Sleeping ☐Social Life
☐Standing ☐Traveling and/or Driving ☐Walking
☐Other_____

What do you have difficulty performing due to this specific complaint? (Choose all the apply)?

☐Bending over ☐Caring for Family ☐Climbing Stairs ☐Concentrating ☐Dressing self ☐ Driving Car ☐Exercising
☐Getting in or out of the car ☐Getting to Sleep ☐Grocery Shopping ☐Performing Household Chores ☐Lifting Objects
☐Looking over shoulder ☐Making Love ☐Lying down ☐Reaching over head ☐Rising our of chair or bed
☐Showering or bathing ☐Sitting ☐Standing ☐Staying asleep ☐Using a Computer ☐Walking ☐Participation in Yard Work
☐Other_____

Have you had surgery? ☐Y ☐ N

1. _____Date: _____
2._____ Date: _____
3._____ Date: _____

Drugs, prescription, OTC, recreational?

1._____ Treating? _____
2._____ Treating? _____
3._____ Treating? _____
4._____ Treating? _____

Vitamins, Minerals, Health drinks?

1._____ 2. _____
3._____ 4. _____

Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

Current Health

Habits:

***Patient Comments**
If answer is Yes (please give more details, ex. How much, How often etc…)

Did/do you smoke? ☐Y ☐ N _____

Did/do you drink alcohol? ☐Y ☐ N _____

Exercise regularly? ☐Y ☐ N **How often?**_____

Did/do you have occupational stress? ☐Y ☐ N _____

Drive? Daily time spent driving ☐Y ☐ N _____

Physical stress? ☐Y ☐ N _____

Emotional/Mental stress? ☐Y ☐ N _____

Hobbies/Sports injuries? ☐Y ☐ N _____

Do you sleep well, hours of sleep? ☐Y ☐ N _____

Sleeping posture? ☐ Side _____☐Stomach_____ ☐Back_____

Do you have urinary, kidney or bladder problems? ☐Y ☐ N _____

Have you lost any weight in the past year without trying to? ☐Y ☐ N _____

Does your pain wake you at night? ☐Y ☐ N _____

Have you had a change in bowel or bladder habits? ☐Y ☐ N _____

Have you had / do you have chest pain? ☐Y ☐ N _____

Have you had a concussion? ☐Y ☐ N _____

Have you had / do you have dislocated joints? ☐Y ☐ N _____

Have you had / do you have headaches? ☐Y ☐ N _____

What are the physical demands of your Job (circle one): Light Moderate Heavy

How would you consider your average diet (circle one): Balanced Fair Poor Excessive Restricted

Do you use any of the following (circle all that apply): Caffeine Tobacco Recreational drugs Soda

Have you been in accidents/trauma? ☐Y ☐ N ☐ Job ☐ Auto ☐ Other 1. _____

Dates of accidents/trauma: _____

List physical injuries such as falls, head injury, sprains, strains, broken bones:

_____

_____

Do You Have Children ☐ None ☐ Boys ages ___ ___ ___ ___ ☐ Girls ages ___ ___ ___ ___?

Are both your parents still alive? ☐Y ☐N (please explain cause(s) death below) example (heart attack):

_____

Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

Medical/Family History S = Self M = Mother F=Father

(Please indicate which **past** conditions have been experienced prior to your present complaint by marking appropriate boxes.)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	abdominal aneurism	☐	☐	☐	AIDS/HIV	☐	☐	☐	alcoholism
☐	☐	☐	alzheimer's	☐	☐	☐	anemia	☐	☐	☐	anorexia
☐	☐	☐	arthritis	☐	☐	☐	asthma	☐	☐	☐	allergies
☐	☐	☐	bleeding disorders	☐	☐	☐	breast lump	☐	☐	☐	bronchitis
☐	☐	☐	bulimia	☐	☐	☐	chemical dependency	☐	☐	☐	depression
☐	☐	☐	diabetes	☐	☐	☐	emphysema	☐	☐	☐	epilepsy / seizures
☐	☐	☐	heart disease	☐	☐	☐	hernia	☐	☐	☐	hepatitis
☐	☐	☐	herniated disc	☐	☐	☐	high blood pressure	☐	☐	☐	high cholesterol
☐	☐	☐	kidney disease	☐	☐	☐	liver disease	☐	☐	☐	migraine
☐	☐	☐	multiple sclerosis	☐	☐	☐	osteoarthritis	☐	☐	☐	osteopenia
☐	☐	☐	osteoporosis	☐	☐	☐	pacemaker	☐	☐	☐	pinched nerve
☐	☐	☐	pneumonia	☐	☐	☐	prostate problems	☐	☐	☐	psychiatric care
☐	☐	☐	rheumatoid arthritis	☐	☐	☐	stroke	☐	☐	☐	suicide attempt
☐	☐	☐	thyroid problems	☐	☐	☐	tumor	☐	☐	☐	venereal disease

☐ ☐ ☐ cancer (please provide the type) _____

☐ ☐ ☐ other illness/injury (explain) _____

Patient Print Name: _____

Patient Signature: _____Date_____