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

Current Health Habits:	Patient Comment 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 ______________________________
Diet, do you eat healthy foods?	☐Y ☐ N ______________________________
Exercise regularly?	☐Y ☐ N ______________________________
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 ______________________________

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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	
☐ ☐ ☐	AIDS	☐ ☐ ☐	Heart trouble	☐ ☐ ☐	Rheumatism
☐ ☐ ☐	anemia	☐ ☐ ☐	Hepatitis	☐ ☐ ☐	Scarlet fever
☐ ☐ ☐	arthritis	☐ ☐ ☐	High / low blood pressure	☐ ☐ ☐	Serious injury
☐ ☐ ☐	asthma /allergies	☐ ☐ ☐	Indigestion / GERD	☐ ☐ ☐	Sinus trouble
☐ ☐ ☐	back pain	☐ ☐ ☐	Kidney disorder	☐ ☐ ☐	Stroke
☐ ☐ ☐	bladder trouble	☐ ☐ ☐	Menstrual cramps	☐ ☐ ☐	Thyroid disease
☐ ☐ ☐	bleeding problems	☐ ☐ ☐	Muscular dystrophy	☐ ☐ ☐	Tuberculosis
☐ ☐ ☐	bone fracture	☐ ☐ ☐	Multiple sclerosis	☐ ☐ ☐	Varicose veins
☐ ☐ ☐	cancer	☐ ☐ ☐	Neck pain	☐ ☐ ☐	Venereal disease
☐ ☐ ☐	contagious skin disorder	☐ ☐ ☐	Nervousness	☐ ☐ ☐	other (explain below)
☐ ☐ ☐	convulsions	☐ ☐ ☐	Numbness	______________________________	
☐ ☐ ☐	diabetes	☐ ☐ ☐	Osteoporosis	______________________________	
☐ ☐ ☐	epilepsy / seizures	☐ ☐ ☐	Polio	______________________________	
☐ ☐ ☐	gallstones	☐ ☐ ☐	Poor circulation		
☐ ☐ ☐	German measles	☐ ☐ ☐	Rheumatic fever		
☐ ☐ ☐	Headaches	☐ ☐ ☐	Abdominal Aortic Aneurysm		

Have you ever been treated by a physician for any health conditions in the last year? ☐ Yes ☐ No

Have you been in accidents/trauma? ☐Y ☐ N ☐ Job ☐ Auto ☐ Other 1. ____________________Date:_________
List physical injuries such as falls, head injury, sprains, strains, broken bones:
____
____

Have you had surgery? ☐Y ☐ N 1. ____ Date:________
2.____ Date: _______
3.____ Date: _______

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):
____

Drugs, prescription, OTC, recreational?
1.____________________________ Treating? ______________________
2.____________________________ Treating? ______________________
3.____________________________ Treating? ______________________
4.____________________________ Treating? ______________________
5.____________________________ Treating? ______________________
6.____________________________ Treating? ______________________

Vitamins, Minerals, Health drinks?
1.____________________________ 2. ___________________________
3.____________________________ 4. ___________________________
5.____________________________ 6. ___________________________

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What are the physical demands of your Job (circle one):	Light	Moderate	Heavy	
What is the stress level you are normally under (circle one):	Low	Medium	High	
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

Symptoms and Present State of Health
Present Complaint/Reason for Seeking Care in this Office:
Primary____
Pain or Problem started on____
Other Doctors seen for this condition____
Any home remedies? ____

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

1. Body Area________________________________ (example: low back, neck, headache)
   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 Occasional Intermittent Frequent

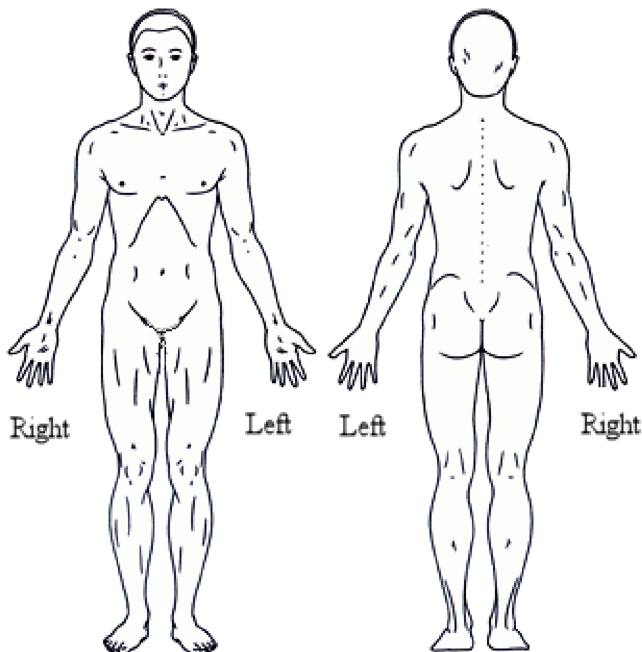
2. Body Area________________________________ (example: low back, neck, headache)
   Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)
   Constant Occasional Intermittent Frequent

3. Body Area________________________________ (example: low back, neck, headache)
   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 Occasional Intermittent Frequent

4. Body Area________________________________ (example: low back, neck, headache)

Please Circle where you are at: (No Complaint/Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Complaint/Pain)

Frequency: Constant Occasional Intermittent Frequent



Using the symbols below, mark on the pictures where you feel pain.

Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _________	^ ^ ^

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Please Check All Activities That are Worsened by Your Present Condition:

General

☐ Walking ☐ Getting in/out of car ☐ Lifting Children ☐ Sexual Intercourse ☐ Bending ☐ Standing
☐ Sitting ☐ Kneeling ☐ Reading ☐ Using Telephone ☐ Lying in bed ☐ Chewing
☐ Climbing Stairs ☐ Sleeping ☐ Swimming ☐ Running ☐ Using Computer

Housework

☐ Doing Laundry ☐ Vacuuming ☐ Ironing ☐ Caring for Pets ☐ Sweeping
☐ Making Beds ☐ Washing Dishes ☐ Carrying Groceries ☐ Cooking

Yard Work

☐ Mowing Lawn ☐ Raking Leaves ☐ Gardening

Personal Grooming

☐ Combing Hair ☐ Shaving ☐ In/Out of Bathtub ☐ Brushing Teeth

Travel

☐ Driving ☐ Riding as passenger

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

☐Coughing ☐Sneezing ☐Straining at Stool ☐Bending ☐Carrying ☐Climbing ☐Climbing a Ladder ☐Climbing Stairs
☐Driving ☐Exercising ☐Getting Out of Bed ☐In/Out of Car ☐Lifting ☐Pulling ☐Pushing ☐Repetitious Movements
☐Standing ☐Stooping ☐Walking Uphill ☐Heat ☐Cold

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:

☐Chiropractic Care (adjustments) ☐Advil ☐Aspirin ☐Pain Pills ☐Tylenol ☐Exercising ☐Reclining ☐Resting ☐Sleeping
☐Walking ☐Cold/Ice pack ☐Massaging by hand ☐Heat ☐Rubbing Heat Liniment ☐Hot Shower ☐Rubbing Mineral Ice
☐Tub Soaking ☐Massaging (vibrator)

Patient Print name: ____

Patient Signature: ____Date______________________