Balance Chiropractic

# Patient Introduction

Date _____

Name _____ Occupation _____

Address _____ Employer _____

City _____ Work address _____

State _____ Zip _____ City _____

Cell phone _____ State _____ Zip _____

Home phone _____

Work phone _____ Emergency contact _____

E-mail address _____ Relationship _____

Gender: □ Male □ Female Phone _____

Date of Birth _____ Age _____

Referred by _____

□ Single □ Married □ Divorced □ Widowed Have you ever been treated by a chiropractor before?

Name of spouse (or parent) _____ □ No □ Yes If yes, when? _____

Number of children _____ Name of family physician _____

**INSURANCE INFORMATION:**

Name of Insurance Carrier _____

Policy Holder _____ Relationship to Patient _____

Policy No. _____ Group No._____

Are you seeking care for injuries sustained in an accident? □ Yes □ No

Type of accident: □ Auto □ Work □ Home □ Other _____

Purpose of this appointment _____

Other doctors seen for this condition/problem _____

Have you been treated for any health problem(s) by a physician this year? □ Yes □ No

Describe _____

Any additional information we need to know _____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Balance Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Balance Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services provided for me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services provided for me will be immediately due and payable.

Signature _____
(if patient is a minor, name of parent or guardian)

# Patient History

The following is a confidential questionnaire which will help us determine the best course of treatment for you. Please take your time and complete the information accurately. Thank you!

Please check the box that indicates your symptoms by using the following codes:

N—Never had P—Previously had C—Currently have

□ N □ P □ C Headaches _____

□ N □ P □ C Neck Problems _____

□ N □ P □ C Pain Between Shoulderblades _____

□ N □ P □ C Low Back Pain _____

□ N □ P □ C Arm Problems _____

□ N □ P □ C Leg Problems _____

□ N □ P □ C Swollen Joints _____

□ N □ P □ C Painful Joints _____

□ N □ P □ C Stiff Joints _____

□ N □ P □ C Sore Muscles _____

□ N □ P □ C Weak Muscles _____

□ N □ P □ C Walking Problems _____

□ N □ P □ C Ruptures _____

□ N □ P □ C Broken Bones _____

□ N □ P □ C Numbness _____

□ N □ P □ C Loss of Feeling _____

□ N □ P □ C Paralysis _____

□ N □ P □ C Dizziness _____

□ N □ P □ C Fainting _____

□ N □ P □ C Muscle Jerking _____

□ N □ P □ C Forgetfulness _____

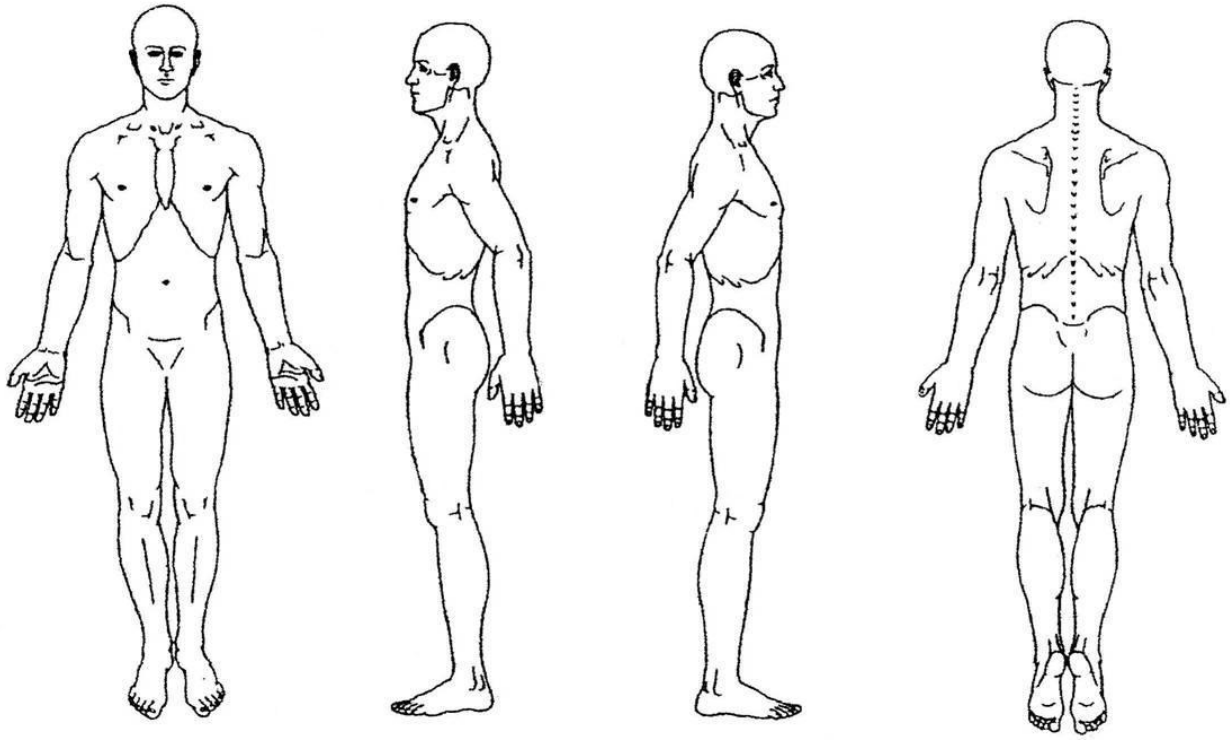
□ N □ P □ C Convulsions _____

□ N □ P □ C Confusion _____

□ N □ P □ C Depression _____

Mark the areas on the figures below where you feel the described sensations. Use the appropriate symbol.
Mark the areas of radiation. Include all affected areas.

| Numbness | Dull Ache | Hot burning | Sharp Stabbing | Pins & Needles |
|---|---|---|---|---|
| === | 000 | XXX | /// | +++ |



Balance Chiropractic 120 W. Olive Ave., Monrovia, CA 91016 Tel: (626) 357-2222 Fax: (626) 605-5155 www.bal-chiropractic.com

Please list all your past accidents, injuries, surgeries, and hospitalizations

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

_____ Date or Age _____

What medications, vitamins, supplements, herbs do you take?

| **Name** | **Reason** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please list any allergies that you have

_____

Do you or other family members have a history of any of the following?

| | | |
|---|---|---|
| Arthritis | □ Self | Family member _____ |
| Asthma | □ Self | Family member _____ |
| Cancer | □ Self | Family member _____ |
| Diabetes | □ Self | Family member _____ |
| Heart Disease | □ Self | Family member _____ |
| Hypertension | □ Self | Family member _____ |
| Hypoglycemia | □ Self | Family member _____ |
| Kidney Disease | □ Self | Family member _____ |
| Depression | □ Self | Family member _____ |
| Mental Illness | □ Self | Family member _____ |

Do you drink coffee or black tea? _____ If so, how much per day? _____

Do you smoke tobacco? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how often? _____

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise your heart rate?_____

When you engage in the physical activity noted above, what is the average duration of activity?

____ Less than 10 minutes ____ 10 – 20 mins ____ 20 – 30 mins ____ 30 – 60 mins ____ 60+ mins

When you engage in the physical activity noted above, what do you feel the level of effort is?_____

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?_____

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) _____