THE BALANCING CENTER

Name:_____ **Birthday:**_____ **Age:**_____ **Sex:** _____

Address:_____ **Height:**_____ **Weight:**_____

City:_____**State:**_____**Zip:**_____ **Married/In Relationship:**_____

Number of Children:____ **Age(s):**_____

Primary Phone:_____ **E-mail:**_____

Secondary Phone:_____ **Referred by:**_____

Occupation:_____ **If not referred by anyone, how did you hear about us?:**_____

Hobbies/Interests:_____

_____

_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Have you been to a Chiropractor before? ☐ Yes ☐ No **Are you a Medicare Patient?** ☐ Yes ☐ No

What is the reason for your visit today? ☐ Relief ☐ Information ☐ Wellbeing

"Although our philosophy is that pain is only a surface indicator of deeper issues, health challenges, or body responses, completing this section will help us get a fast track to understanding what you are experiencing and how we can help"

1. Check any of the following conditions or symptoms you have experienced and circle the ones that affect you most:

☐ Headache/Migraines	☐ Stomach Problems	☐ Low Back and Hip Pain	☐ Mid Back Pain
☐ Sinus /Allergies	☐ Low Energy/Tired	☐ Sciatica	☐ Constipation
☐ Neck Pain	☐ Numbness/Tingling	☐ Shoulder/Arm Pain	☐ Leg/Knee Pain
☐ Disc Problems	☐ Jaw Pain/Clicking	☐ Asthma	☐ Dizziness/Vertigo
☐ Ear Aches/Tinnitus	☐ Frequent Colds/Flu	☐ Anxiety/Depression	☐ Stress

Are any of the above a result of an accident? ☐ Yes ☐ No

Other Health Concerns: _____

_____

2. Check all true statements.

These conditions disturb my…	I have tried…	I have found…
☐ Career	☐ Exercise	☐ Previous help to be ineffective.
☐ Social/ Family Life	☐ Physical Therapy	☐ I am worried my problems could get worse.
☐ Ability to Exercise	☐ Massage/Bodywork	☐ I want more energy.
☐ Sleeping Patterns	☐ Supplements	☐ I want answers and fast results.
☐ Quality of Life	☐ Prescription Drugs	☐ I want better health.
☐ Other: _____	☐ Surgery	☐ Nothing

3. How long have you been living this way? Weeks (#) _____ Months (#)_____ Years (#)_____

4. What barriers have stopped you from achieving optimal health?

☐ Money ☐ Time ☐ Other: _____

Signature_____ Date_____

By the time one feels pain, a chain of imbalance has already occurred. During the process of getting you relief, we identify and help resolve the underlying cause of your condition that will allow you to restore optimal health, function, and vitality. This section will give us a picture of your health history.

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Mark (c) for current problems, check the box *and* indicate age when you had any of the following:

General
☐ Fainting
☐ Fever
☐ Headaches
☐ Loss of sleep
☐ Mental illness
☐ Tremors
☐ Weight loss/gain

Muscle/Joint
☐ Arthritis/Rheumatism
☐ Bursitis
☐ Foot trouble
☐ Muscle Weakness

Skin
☐ Acne
☐ Bruise easily
☐ Dryness
☐ Hives or allergies
☐ Itching
☐ Rash
☐ Varicose veins

Eye, Ear, Nose & Throat
☐ Deafness
☐ Eye pain
☐ Gum trouble
☐ Hoarseness
☐ Nasal obstruction
☐ Wheezing
☐ Nose bleeds
☐ Sinus infection
☐ Sore throat
☐ Tonsillitis
☐ Vision problems

Gastrointestinal
☐ Abdominal pain
☐ Bloody or tarry stool
☐ Colitis/Crohn's
☐ Colon trouble
☐ Constipation
☐ Diarrhea
☐ Diverticulosis
☐ Bloated abdomen
☐ Excessive hunger
☐ Gallbladder trouble
☐ Hernia
☐ Hemorrhoids
☐ Intestinal worms
☐ Jaundice
☐ Liver trouble
☐ Nausea
☐ Painful defecation
☐ Pain over stomach
☐ Poor appetite
☐ Vomiting
☐ Vomiting of blood

Genitourinary
☐ Bed-wetting
☐ Bladder infection
☐ Blood in urine
☐ Kidney infection
☐ Kidney stones
☐ Prostate trouble
☐ Stress incontinence
Urination:
☐ Overnight more than twice
☐ More than 8x in 24hrs
☐ Decreased flow/force
☐ Painful urination

Cardiovascular
☐ High blood pressure
☐ Low blood pressure
☐ Hardening of the arteries
☐ Irregular pulse
☐ Pain over heart
☐ Palpitations
☐ Poor circulation
☐ Rapid heart beat
☐ Slow heart beat
☐ Swelling of ankles

Respiratory
☐ Chest pain
☐ Chronic cough
☐ Difficulty breathing
☐ Shortness of breath
☐ Spitting up phlegm/ blood
☐ Wheezing

Women Only
☐ Congested breasts
☐ Hot flashes
☐ Lumps in breasts
☐ Menopause
☐ Vaginal discharge
☐ Pregnant
Date of last cycle:
_____

Check any conditions you have/or have had:
☐ Alcoholism
☐ Anemia
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Bronchitis
☐ Cancer
☐ Chicken pox
☐ Cold sores
☐ Diabetes
☐ Eczema
☐ Edema
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart burn
☐ Heart disease
☐ Hepatitis
☐ Herpes
☐ High cholesterol
☐ HIV/AIDS
☐ Influenza
☐ Malaria
☐ Measles
☐ Miscarriage
☐ Multiple sclerosis
☐ Mumps
☐ Oseteoporosis
☐ Pace Maker
☐ Pneumonia
☐ Polio
☐ Psoriasis
☐ Rheumatic fever
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers

Current/Recent Doctors Seen	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any medications you are currently taking and why: _____

_____

_____

_____

_____