



PAST HEALTH HISTORY			
PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF "DENY"			
<b>Childhood Illness:</b>	<input type="checkbox"/> ADD <input type="checkbox"/> Allergies/Hay fever <input type="checkbox"/> Asthma <input type="checkbox"/> Atopic Dermatitis (Eczema) <input type="checkbox"/> Bedwetting <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infections <input type="checkbox"/> Fetal Drug Exposure <input type="checkbox"/> Food Allergies <input type="checkbox"/> Headaches <input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> Rash <input type="checkbox"/> Scoliosis <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Sickle Cell Anemia
			<input type="checkbox"/> Spina Bifida <input type="checkbox"/> Other (Please Be Specific): _____ _____ <input type="checkbox"/> Deny Any <b>Childhood Illness</b>
<b>Adult Illness:</b>	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Crohn's/Colitis <input type="checkbox"/> CRPS (RSD) <input type="checkbox"/> CVA (stroke) <input type="checkbox"/> Cystic Kidney Disease <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes (Insulin)	<input type="checkbox"/> Diabetes (Non-Insulin) <input type="checkbox"/> Ear Infections (Frequent) <input type="checkbox"/> Emphysema <input type="checkbox"/> Eye Problems <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Hypertension <input type="checkbox"/> Influenzal Pneumonia <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Disease	<input type="checkbox"/> Lupus Erythema (Discoid) <input type="checkbox"/> Lupus Erythema (Systemic) <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pleurisy <input type="checkbox"/> Pneumonia <input type="checkbox"/> Psychiatric Problems <input type="checkbox"/> Scoliosis <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> STD's (Unspecified) <input type="checkbox"/> Suicide Attempt(s) <input type="checkbox"/> Shingles
			<input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Vertigo <input type="checkbox"/> Past history of similar symptoms to your current condition <input type="checkbox"/> Other (Please Be Specific): _____ _____ <input type="checkbox"/> Deny Any <b>Adult Illness</b>
<b>Surgeries:</b>	<input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Caesarian Section <input type="checkbox"/> Carpal Tunnel Repair <input type="checkbox"/> Cardiac Catheterization <input type="checkbox"/> Coronary Artery Bypass <input type="checkbox"/> Cosmetic	<input type="checkbox"/> D & C <input type="checkbox"/> Dental Surgery <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Joint Reconstruction	<input type="checkbox"/> Joint Replacement <input type="checkbox"/> Laminectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Pacemaker Insertion <input type="checkbox"/> Rotator Cuff <input type="checkbox"/> Spinal Fusion <input type="checkbox"/> Tonsilectomy
			<input type="checkbox"/> Other (Please Be Specific): _____ _____ <input type="checkbox"/> Deny Any <b>Surgery</b>
<b>Injuries:</b>	<input type="checkbox"/> Back Injury <input type="checkbox"/> Broken Bones <input type="checkbox"/> Disability <input type="checkbox"/> Fall (Severe)	<input type="checkbox"/> Fracture <input type="checkbox"/> Head Injury <input type="checkbox"/> Industrial Accident <input type="checkbox"/> Joint Injury	<input type="checkbox"/> Laceration (Severe) <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Soft Tissue Injury (Mild) <input type="checkbox"/> Soft Tissue Injury (Severe)
			<input type="checkbox"/> Other (Please Be Specific): _____ _____ <input type="checkbox"/> Deny Any <b>Injury</b>
<b>Immunizations:</b>	<input type="checkbox"/> Flu <input type="checkbox"/> Influenza <input type="checkbox"/> Varivax (Chicken Pox) <input type="checkbox"/> Small Pox <input type="checkbox"/> PPD (Mantoux Test-TB)	<input type="checkbox"/> Hepatitis C <input type="checkbox"/> IPV (Polio) <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> TB	<input type="checkbox"/> DTaP(Diphtheria, Tetanus, Pertussis) <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Whooping Cough (Pertussis)
			<input type="checkbox"/> Other (Please Be Specific): _____ _____ <input type="checkbox"/> Deny Any <b>Immunization</b>
<b>Non-Drug Allergies:</b>	<input type="checkbox"/> Animals <input type="checkbox"/> Dairy <input type="checkbox"/> Eggs	<input type="checkbox"/> Food Coloring <input type="checkbox"/> Mold <input type="checkbox"/> Pollen <input type="checkbox"/> Wheat	<input type="checkbox"/> Other (Please Be Specific): _____ _____ <input type="checkbox"/> Deny Any <b>Non-Drug Allergy</b>

REVIEW OF SYSTEMS			
PLEASE FILL OUT ALL OF THE SECTIONS, EVEN IF "DENY"			
<b>Constitutional:</b>	<input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Daytime Somnolence (Drowsiness)	<input type="checkbox"/> Weight Gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Deny Any <b>Constitutional Issue</b>
<b>Eyes/Vision:</b>	<input type="checkbox"/> Blindness <input type="checkbox"/> Eye Pain <input type="checkbox"/> Tearing <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Field Cuts (Visual Field Defect)	<input type="checkbox"/> Wear Glasses and/or Contact Lenses <input type="checkbox"/> Change in Vision <input type="checkbox"/> Itching (Around the Eyes) <input type="checkbox"/> Photophobia <input type="checkbox"/> Double Vision	<input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Deny Any <b>Eyes/Vision Issue</b>

<b><u>Ears, Nose &amp; Throat:</u></b>	<input type="checkbox"/> Bleeding <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Snoring <input type="checkbox"/> Dental Implants <input type="checkbox"/> Ear Drainage <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Ear Pain	<input type="checkbox"/> Head Injury (History of) <input type="checkbox"/> Nose Bleeds (Frequent) <input type="checkbox"/> Sore Throats (Frequent) <input type="checkbox"/> Dentures <input type="checkbox"/> Ear Infections(s) <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Tinnitus (Ringing in Ears) <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Rhinorrhea (Runny nose) <input type="checkbox"/> Discharge <input type="checkbox"/> Fainting <input type="checkbox"/> TMJ  <input type="checkbox"/> Deny Any <b><u>Ears, Nose &amp; Throat Issue</u></b>
<b><u>Respiration:</u></b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Sputum Production	<input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing	<input type="checkbox"/> Deny Any <b><u>Respiration Issue</u></b>
<b><u>Cardiovascular:</u></b>	<input type="checkbox"/> Varicose Veins <input type="checkbox"/> Swelling of Legs <input type="checkbox"/> Angina (Chest Pain) <input type="checkbox"/> Palpitations (Irregular or Forceful Beating of the Heart) <input type="checkbox"/> Shortness of Breath with Exertion or Exercise	<input type="checkbox"/> Claudication (Leg Pain or Achiness) <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Paroxysmal Nocturnal Dyspea (Waking at Night With Shortness of Breath) <input type="checkbox"/> Orthopnea (Difficulty Breathing While Lying Down)	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Problems <input type="checkbox"/> Ulcers  <input type="checkbox"/> Deny Any <b><u>Cardiovascular Issue</u></b>
<b><u>Gastrointestinal:</u></b>	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Abnormal Stool Consistency <input type="checkbox"/> Belching <input type="checkbox"/> Abnormal Stool Caliber (Quality) <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Black, Tarry Stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Vomiting <input type="checkbox"/> Abnormal Stool Color <input type="checkbox"/> Jaundice (Yellowing of Skin)	<input type="checkbox"/> Constipation <input type="checkbox"/> Indigestion <input type="checkbox"/> Vomiting Blood  <input type="checkbox"/> Deny Any <b><u>Gastrointestinal Issue</u></b>
<b><u>Endocrine:</u></b>	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Voice Changes	<input type="checkbox"/> Goiter <input type="checkbox"/> Excessive Appetite <input type="checkbox"/> Hair Loss <input type="checkbox"/> Unusual Hair Growth <input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Excessive Hunger  <input type="checkbox"/> Deny Any <b><u>Endocrine Issue</u></b>
<b><u>Skin:</u></b>	<input type="checkbox"/> Changes in Nail Texture <input type="checkbox"/> Paresthesia (Numbness, Prickling, or Tingling) <input type="checkbox"/> History of Skin Disorders <input type="checkbox"/> Itching	<input type="checkbox"/> Changes in Skin Color <input type="checkbox"/> Hair Growth <input type="checkbox"/> Rash <input type="checkbox"/> Varicosities <input type="checkbox"/> Hair Loss	<input type="checkbox"/> Skin Lesions/Ulcers <input type="checkbox"/> Hives  <input type="checkbox"/> Deny Any <b><u>Skin Issue</u></b>
<b><u>Nervous System:</u></b>	<input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Stress <input type="checkbox"/> Facial Weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Unsteadiness of Gait	<input type="checkbox"/> Strokes <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Limb Weakness <input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Slurred Speech  <input type="checkbox"/> Deny Any <b><u>Nervous System Issue</u></b>
<b><u>Psychologic:</u></b>	<input type="checkbox"/> Anhedonia (Inability to Experience Joy or Enjoy Life) <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Memory Loss <input type="checkbox"/> Confusion	<input type="checkbox"/> Behavioral Change(s) <input type="checkbox"/> Mood Change(s) <input type="checkbox"/> Anxiety <input type="checkbox"/> Convulsions <input type="checkbox"/> Appetite Change	<input type="checkbox"/> Insomnia  <input type="checkbox"/> Deny Any <b><u>Psychologic Issue</u></b>
<b><u>Allergy:</u></b>	<input type="checkbox"/> Anaphylaxis (History of) <input type="checkbox"/> Food Intolerance	<input type="checkbox"/> Itching <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Sneezing	<input type="checkbox"/> Deny Any <b><u>Allergy Issue</u></b>
<b><u>Hematology:</u></b>	<input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Blood Clotting	<input type="checkbox"/> Blood Transfusion(s) <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Lymph Node Swelling	<input type="checkbox"/> Fatigue  <input type="checkbox"/> Deny Any <b><u>Hematology Issue</u></b>

SOCIAL HISTORY			
<b>Diet (Please Mark All That Apply):</b>	<input type="checkbox"/> High Fat <input type="checkbox"/> High Fiber <input type="checkbox"/> High Protein	<input type="checkbox"/> High Salt <input type="checkbox"/> Low Sugar <input type="checkbox"/> Low Calorie	<input type="checkbox"/> Low Carb. <input type="checkbox"/> Low Fiber <input type="checkbox"/> Low Salt <input type="checkbox"/> Other (Please Be Specific): _____
<b>Education (Please Mark the Highest Level Completed):</b>	<input type="checkbox"/> Preschool <input type="checkbox"/> Elementary <input type="checkbox"/> Middle <input type="checkbox"/> Junior High <input type="checkbox"/> In High School	<input type="checkbox"/> Did Not Finish High School <input type="checkbox"/> High School Diploma <input type="checkbox"/> Post High School Classes <input type="checkbox"/> Votech <input type="checkbox"/> In College	<input type="checkbox"/> Assoc/Technical Degree <input type="checkbox"/> College Degree <input type="checkbox"/> In Graduate School <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Doctorate <input type="checkbox"/> Other(Please Be Specific): _____
<b>Drugs:</b>	<input type="checkbox"/> Deny Any Illegal Drug Use <input type="checkbox"/> Deny Use of IV Drugs <input type="checkbox"/> Have not used drugs since: _____ <input type="checkbox"/> Have used drugs for: _____		
<b>Tobacco:</b>	<input type="checkbox"/> Deny Tobacco Use <input type="checkbox"/> Live With a Smoker <input type="checkbox"/> Quit Smoking	<input type="checkbox"/> Smoke # _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> Chew # _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
<b>Alcohol:</b>	<input type="checkbox"/> Never <input type="checkbox"/> Social Consumption Only	<input type="checkbox"/> Drink _____ oz. or _____ glasses per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	<input type="checkbox"/> Beer <input type="checkbox"/> Liquor <input type="checkbox"/> Wine

♀ WOMEN ONLY		
Age at Onset of Menstruation:	Date of Last Menstruation:	Period Every _____ Days
Do you regularly experience... <input type="checkbox"/> Heavy Periods <input type="checkbox"/> Irregularity <input type="checkbox"/> Spotting <input type="checkbox"/> Pain <input type="checkbox"/> Discharge		
Have you recently experienced... <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Lumps in the Breast <input type="checkbox"/> Nipple Discharge		
Any hot flashes or sweating at night? <input type="checkbox"/> Yes <input type="checkbox"/> No		
At or around the time of your period, do you experience... <input type="checkbox"/> Menstrual Tension <input type="checkbox"/> Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Irritability <input type="checkbox"/> Other Symptoms (Explain):		
Are you currently... <input type="checkbox"/> Pregnant <input type="checkbox"/> Breastfeeding	Have you had... <input type="checkbox"/> D&C <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Caesarian	
Number of Pregnancies _____ Number of Live Births _____		
In the last year, have you had infection of the... <input type="checkbox"/> Urinary Tract <input type="checkbox"/> Bladder <input type="checkbox"/> Kidney		
Any blood in your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems with control of urination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Last Pap Exam:	Date of Last Rectal Exam:	

♂ MEN ONLY		
Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times: _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Within the last 12 months have you had... <input type="checkbox"/> Prostate Infections <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Kidney Infections		
Date of Last Prostate Exam:	Date of Last Rectal Exam:	

# Chief Complaint – HPI (History of Present Illness)

## Back In Balance chiropractic

Patient Name:		Date: / /		Dr.	
Chief Complaint:					
<b>Body Area(s) Involved:</b>	<input type="checkbox"/> Cervical <input type="checkbox"/> Spine, Ribs, Pelvis		<input type="checkbox"/> Upper Extremity		<input type="checkbox"/> Lower Extremity
<b>Condition:</b>	<input type="checkbox"/> New <input type="checkbox"/> Recurring		<input type="checkbox"/> Exacerbation		<input type="checkbox"/> Chronic
<b>Mechanism of Onset:</b>	<input type="checkbox"/> Auto (see accident history form) <input type="checkbox"/> Work... <input type="checkbox"/> Fall <input type="checkbox"/> Lifting <input type="checkbox"/> Overexertion <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Other (see accident history form) <input type="checkbox"/> Other... <input type="checkbox"/> Etiology Unknown <input type="checkbox"/> Overexertion <input type="checkbox"/> Repetitive Use <input type="checkbox"/> Slept Wrong <input type="checkbox"/> Slip or Fall <input type="checkbox"/> No Injury (see below)				
<b>Symptoms:</b>	<input type="checkbox"/> Pain <input type="checkbox"/> Numbness		<input type="checkbox"/> Stiffness		<input type="checkbox"/> Weakness
<b>Location:</b>	Left / Right / Bilateral				
<b>Quality:</b>	<input type="checkbox"/> Burning <input type="checkbox"/> Diffuse <input type="checkbox"/> Dull/Aching <input type="checkbox"/> Localized <input type="checkbox"/> Sharp		<input type="checkbox"/> Shooting		<input type="checkbox"/> Stabbing
	<input type="checkbox"/> Tingling <input type="checkbox"/> Throbbing <input type="checkbox"/> Tightness <input type="checkbox"/> Radiating <input type="checkbox"/> Other:				
<b>Level of Impairment Due to Symptoms (Resting):</b>					
0      1      2      3      4      5      6      7      8      9      10					
<b>Level of Impairment Due to Symptoms (With Activity):</b>					
0      1      2      3      4      5      6      7      8      9      10					
<b>Duration:</b>	Symptom(s) Started: Symptom(s) Last Episode:		Symptom(s) Worsened: Injury Occurred:		Symptom(s) Last Occurred: Accident Occurred:
<b>Timing:</b>	<b>Worse in the:</b> <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Night <input type="checkbox"/> With Activity <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent				
<b>Context:</b>	<b>Better with:</b> <input type="checkbox"/> Warm Temp <input type="checkbox"/> Cold Temp		<b>Worse with:</b> <input type="checkbox"/> Warm Temp <input type="checkbox"/> Cold Temp <input type="checkbox"/> Damp		
<b>Assoc Signs and Symptoms:</b>	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches (see below) <input type="checkbox"/> Stiffness <input type="checkbox"/> Irritability/Mood Swing <input type="checkbox"/> Localized Tingling <input type="checkbox"/> Nausea <input type="checkbox"/> Ringing in Ears				
<b>Headaches:</b>	<b>Location:</b> <input type="checkbox"/> Occipital <input type="checkbox"/> Frontal		<input type="checkbox"/> Temporal <input type="checkbox"/> Parietal <input type="checkbox"/> Sinus		
	<b>Quality:</b> <input type="checkbox"/> Dull <input type="checkbox"/> Sharp		<input type="checkbox"/> Throbbing <input type="checkbox"/> Stabbing <input type="checkbox"/> Aura		
	<b>Types:</b> <input type="checkbox"/> Hat Band <input type="checkbox"/> Cluster		<input type="checkbox"/> Migraine <input type="checkbox"/> Tension <input type="checkbox"/> No Aura		
<b>Radiation:</b>	Left / Right / Bilateral				
<b>Weakness:</b>	Left / Right / Bilateral				
<b>Other Assoc Signs and Symptoms:</b>	<input type="checkbox"/> Aches <input type="checkbox"/> Cold Limb <input type="checkbox"/> Dizziness <input type="checkbox"/> Ecchymosis <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Heartburn <input type="checkbox"/> Muscle Spasm <input type="checkbox"/> Nausea <input type="checkbox"/> Weakness <input type="checkbox"/> Swelling <input type="checkbox"/> Pale Bluish Skin <input type="checkbox"/> Panic <input type="checkbox"/> Pins & Needles <input type="checkbox"/> Runny Nose <input type="checkbox"/> SOB <input type="checkbox"/> Vomiting <input type="checkbox"/> Sweating				
<b>Symptoms Better With:</b>	<input type="checkbox"/> Activity <input type="checkbox"/> Bending <input type="checkbox"/> Cold <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> Walking <input type="checkbox"/> Twisting <input type="checkbox"/> Nothing <input type="checkbox"/> Movement <input type="checkbox"/> OTC Meds <input type="checkbox"/> Rx Meds <input type="checkbox"/> Rest <input type="checkbox"/> Stretching <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Helps				
<b>Symptoms Worse With:</b>	(as noted in Social History)				
Since condition began, has anything permanently helped you? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has anything that you have done, thus far, fixed you problem? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>EMPLOYMENT</b>					
Occupation:			Work ( hrs / day ):		
<b>Job Classification:</b>	<input type="checkbox"/> Sedentary (<5lbs) <input type="checkbox"/> Light (6-20lbs)		<input type="checkbox"/> Moderate (21-49lbs)		<input type="checkbox"/> Heavy (>50 lbs)
<b>Lifting Frequency:</b>	<input type="checkbox"/> Constant (66-100%/day) <input type="checkbox"/> Frequent (33-65%/day) <input type="checkbox"/> Occasional (0-32%/day)				
<b>Lifting Postures:</b>	<input type="checkbox"/> Torso <input type="checkbox"/> Knee <input type="checkbox"/> Arm <input type="checkbox"/> Shoulder <input type="checkbox"/> High Near <input type="checkbox"/> Off Posture				
<b>Work Activity Postures:</b> (hrs/day)	Sitting: _____ Standing: _____ Walking: _____ Climbing: _____ Pushing: _____ Pulling: _____ Kneeling: _____ Reaching: _____ Twisting: _____				
<b>Repetitive Activities:</b> (hrs/day)	Computer: _____ Phone: _____ Machinery: _____ Hand Tools: _____ Assembly: _____ Grasping: _____				
<b>Condition's Effect On Job Performance:</b>	<input type="checkbox"/> <b>Mild</b> Painful (can do) <input type="checkbox"/> <b>Mod/Sev</b> (limited duty) <input type="checkbox"/> <b>Sev</b> (can't do limited duty) <input type="checkbox"/> <b>Mod</b> Painful (limits ability) <input type="checkbox"/> <b>Sev</b> (no limited duty)				

<b>EFFECT OF CONDITION ON DAILY ACTIVITIES</b>				
<b>Care –Infirm Family:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Carrying Groceries:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Change Position (Sitting - Standing):</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Climbing Stairs:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Daily Pet Care:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Driving:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Ext Computer Use:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Household Chores:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Lift Children:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Self Care–Bathing:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Self Care–Dressing:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Self Care–Shaving:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Sexual Activities:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Sleep:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Static Sitting:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Static Standing:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Walking:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>Yard Work:</b>	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
<b>EFFECTS OF CONDITION ON RECREATIONAL ACTIVITY</b>				
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform
_____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Mild Painful (Can do)	<input type="checkbox"/> Mod Painful (Limited)	<input type="checkbox"/> Severe Unable to Perform

# BACK IN BALANCE CHIROPRACTIC

## CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Today's Date:    /    /	Primary Care Physician:
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### PATIENT INFORMATION

Last Name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One) Single / Married / Divorced / Widow / Other
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	

Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Former Name (If Any):	Birth Date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address:	Social Security #:	Home Phone #: (    )
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City:	State:	ZIP Code:	Email Address:
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Occupation:	Employer:	Employer Phone #: (    )
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Referred to Back in Balance Chiropractic by:					
<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Dr. _____			
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	

Other Family Members Seen Here:

### IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Home Phone #: (    )	Work Phone #: (    )
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### INSURANCE INFORMATION

(Please give your insurance card to the receptionist to copy for our records)

Person Responsible for Bill:	Birth Date: / /	Home Phone #: (    )	Address (If Different):
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Is this person a patient here?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please indicate type of account:	<input type="checkbox"/> Self Pay	<input type="checkbox"/> Worker's Comp	<input type="checkbox"/> Auto Insurance	<input type="checkbox"/> Medicare	<input type="checkbox"/> MaineCare
	<input type="checkbox"/> Other (Be Specific):				

Name of Primary Insurance:	Subscriber's Name:	Subscriber's S.S. #:	Birth Date: / /
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Group #:	Policy #:
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Patient's Relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
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Name of Secondary Insurance (If Applicable):	Subscriber's Name:	Subscriber's S.S. #:	Birth Date: / /
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Group #:	Policy #:
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Patient's Relationship to Subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Back In Balance Chiropractic or my insurance company(ies) to release any information required to process my claims.

Patient/Guardian Signature	Date
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