BACK IN BALANCE wellness center

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www.backinbalancechiro.com

ADULT **NEW PATIENT FORM**

We comply with all federal privacy standards - all information you supply remains confidential.

Today's Date (MM/DD/YYYY)

Patient Number *(Office Use Only)*

Whom may we thank for referring you? ○ PCP ○ Yellow Pages ○ Internet ○ T.V. ○ Hospital ○ Radio ○ Event ○ Family/Friend

Full Name

Social Security Number

Birth Date *(MM/DD/YYYY)*

Gender ○ Male ○ Female

Age

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

Race

City

State/Province

Zip/Postal Code

Ethnicity

Home Phone

Cell Phone

Preferred Language

Email Address

Spouse's Name

Emergency Contact

Child's Name and Age

Child's Name and Age

Child's Name and Age

Emergency Contact's Phone

Occupation

Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City

State/Province

Zip/Postal Code

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Text

Primary Care Provider's Name

Primary Care Provider's Phone Number

Insurance Carrier

Policy Number

Insured's Full Name

Group Number

Who carries this policy? ○ Self ○ Spouse ○ Parent

Secondary Insurance? ○ *Yes* ○ *No*

Birth Date *(MM/DD/YYYY)*

Do you have a pre-tax healthcare account? ○ HRA ○ HSA ○ FSA ○ POP ○ *N/A*

Insured's Employer

Secondary Insurance Carrier

Address

Employer's Phone

Secondary Insurance Policy Number

City

State/Province

Zip/Postal Code

Secondary Insurance Group Number

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include - Please list in order of priority:

_____

2. And are the result of *(darken circle)*: ◯ An accident or injury: ◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

3. Onset - *When did you first notice your current symptoms?*

_____

4. Intensity - *How extreme are your current symptoms?*

Absent — Mild — Moderate — Agonizing

5. Duration and Timing - *When did it start and how often do you feel it?*

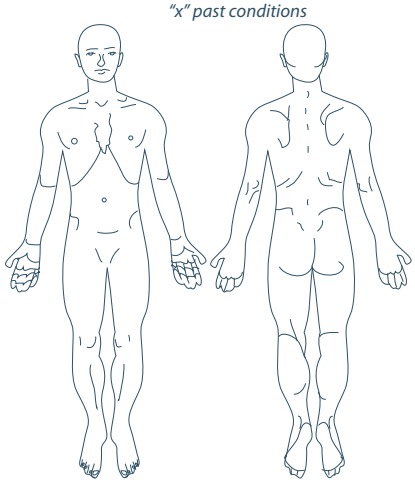
◯ Comes and goes ◯ Constant

How Often? _____

6. Quality of symptoms
What does it feel like?

- ◯ Numbness
- ◯ Tingling
- ◯ Stiffness
- ◯ Dull
- ◯ Aching
- ◯ Cramps
- ◯ Nagging
- ◯ Sharp
- ◯ Burning
- ◯ Shooting
- ◯ Throbbing
- ◯ Stabbing
- ◯ Other _____

7. Location - *Where does it hurt? Circle the area(s)*
*"0" **current** conditions*
"x" past conditions



8. Radiation - *Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.*

_____

9. Aggravating or relieving factors
What makes it better or worse, such as time of day, movements, certain activities, etc.
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions
What have you done to relieve the symptoms?

- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat
- ◯ Other _____

11. What else should we know about your condition? _____

_____

12. Review of Systems - *Darken the circle of any condition that you've **HAD** or currently **HAVE**.*

a. Musculoskeletal		b. Neurological		c. Cardiovascular		d. Respiratory		e. Digestive	
Had	*Have*	*Had*	*Have*	*Had*	*Have*	*Had*	*Have*	*Had*	*Have*
◯	◯ Osteoporosis	◯	◯ Anxiety	◯	◯ High blood pressure	◯	◯ Asthma	◯	◯ Anorexia/bulimia
◯	◯ Knee injuries	◯	◯ Depression	◯	◯ Low blood pressure	◯	◯ Apnea	◯	◯ Ulcer
◯	◯ Arthritis	◯	◯ Headache	◯	◯ High cholesterol	◯	◯ Emphysema	◯	◯ Food sensitivities
◯	◯ Foot/ankle pain	◯	◯ Dizziness	◯	◯ Poor circulation	◯	◯ Hay fever	◯	◯ Heartburn
◯	◯ Scoliosis	◯	◯ Pins and Needles	◯	◯ Angina	◯	◯ Shortness of breath	◯	◯ Constipation
◯	◯ Shoulder problems	◯	◯ Numbness	◯	◯ Excessive bruising	◯	◯ Pneumonia	◯	◯ Diarrhea
◯	◯ Neck pain	◯	◯ Facial Weakness	◯	◯ Anemia	◯	◯ Chest Tightness	◯	◯ Rectal Bleeding
◯	◯ Elbow/wrist pain	◯	◯ Insomnia	◯	◯ Blood Clotting	◯	◯ COPD	◯	◯ Nausea
◯	◯ Back problems	◯	◯ Mood Changes	◯	◯ Heart Disease	◯	◯ Wheeze	◯	◯ Hemorrhoids/Fissures
◯	◯ TMJ issues	◯	◯ Seizures	◯	◯ Leg Pain	◯	◯ Pain with Deep Breath	◯	◯ Abdominal Pain
◯	◯ Hip disorders	◯	◯ Loss of Memory	◯	◯ Sleep Apnea	◯	◯ Bloody Mucus	◯	◯ Black/Gray Stool
◯	◯ Poor posture	◯	◯ Stroke	◯	◯ Varicose Veins	◯	◯ Snoring	◯	◯ GERD
	◯ **NONE**		◯ **NONE**		◯ **NONE**		◯ **NONE**		◯ **NONE**

f. Sensory		g. Skin		h. Endocrine		i. Genitourinary		j. Constitutional	
Had	*Have*	*Had*	*Have*	*Had*	*Have*	*Had*	*Have*	*Had*	*Have*
◯	◯ Blurred vision	◯	◯ Skin cancer	◯	◯ Thyroid issue	◯	◯ Kidney stones	◯	◯ Fainting
◯	◯ Ringing in ears	◯	◯ Psoriasis	◯	◯ Immune disorders	◯	◯ Infertility	◯	◯ Low libido
◯	◯ Hearing loss	◯	◯ Eczema	◯	◯ Hypoglycemia	◯	◯ Bed wetting	◯	◯ Poor appetite
◯	◯ Chronic ear infection	◯	◯ Acne	◯	◯ Frequent infection	◯	◯ Prostate issues	◯	◯ Fatigue
◯	◯ Loss of smell	◯	◯ Hair loss	◯	◯ Swollen glands	◯	◯ Erectile dysfunction	◯	◯ Sudden weight gain/loss *(pick on)*
◯	◯ Loss of taste	◯	◯ Rash	◯	◯ Low energy	◯	◯ PMS symptoms	◯	◯ Weakness
	◯ **NONE**		◯ **NONE**		◯ **NONE**		◯ **NONE**		◯ **NONE**

Patient Name

Patient Number *(Office Use Only)*

CONSULTATION NOTES

Doctor's Signature

Date

Past, Personal, Family and Social History

PERSONAL

13. Illnesses - *Check the illnesses you have **HAD** in the past or **HAVE** now.*

Had	Have	
☐	○	Aids
☐	○	Alcoholism
☐	○	Allergies
☐	○	Arteriosclerosis
☐	○	Cancer
☐	○	Chicken pox
☐	○	Diabetes
☐	○	Epilepsy
☐	○	Glaucoma
☐	○	Goiter
☐	○	Gout
☐	○	Heart disease
☐	○	Hepatitis
☐	○	HIV Positive
☐	○	Malaria
☐	○	Measles
☐	○	Multiple Sclerosis
☐	○	Mumps
☐	○	Polio
☐	○	Rheumatic fever
☐	○	Scarlet fever
☐	○	Sexually transmitted disease
☐	○	Stroke
☐	○	Tuberculosis
☐	○	Typhoid fever
☐	○	Ulcer
☐	○	Other: _____

15. Operations - *Surgical interventions, with or without hospitalization.*

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments - *Check for **PAST** or **CURRENT**.*

Past	Current	
☐	○	Acupuncture
☐	○	Antibiotics
☐	○	Birth control pills
☐	○	Blood transfusions
☐	○	Chemotherapy
☐	○	Chiropractic care
☐	○	Dialysis
☐	○	Herbs
☐	○	Homeopathy
☐	○	Hormone replacement
☐	○	Inhaler
☐	○	Massage therapy
☐	○	Physical therapy
☐	○	Nutritional supplements:

17. Injuries- *Have you ever...*

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other supports
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

FAMILY

14. Family History - *Some health issues are hereditary, Tell us about the health of your immediate family members.*

Relative	Age (if living)	State of health: Good	State of health: Poor	State of health	Age at death	Cause of death: Natural	Cause of death: Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

15. Are there any other hereditary health issues that you know about? _____

_____

SOCIAL HISTORY

16. Social History - *Tell us about your health habits and stress levels.*

Alcohol use	○ Never	○ Daily	○ Weekly	How much? _____
Coffee use	○ Never	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Never	○ Daily	○ Weekly	How much? _____
Exercising	○ Never	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Never	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Never	○ Daily	○ Weekly	How much? _____
Water intake	○ Never	○ Daily	○ Weekly	How much? _____

Hobbies _____

_____

Prayer or meditation? ○ Yes ○ No Financial peace? ○ Yes ○ No Mercury filings? ○ Yes ○ No

Job pressure/stress? ○ Yes ○ No Vaccinated? ○ Yes ○ No Recreational drugs? ○ Yes ○ No

CONSULTATION NOTES

Patient Name _____

Patient Number *(Office Use Only)* _____

Doctor's Signature _____

Date _____

17. Medications - *Please list all prescription and over-the-counter:* ◯ *Medication List Attached*

_____

_____

18. Additional info - *WOMEN ONLY* ♀

Are you currently pregnant? ◯ Yes ◯ No

Number of Pregnancies ____ Number of Live Births ____

Type of Birth Control _____

Age at Onset of Menstruation _____

Date of Last Period _____ Duration of Flow _____

Number of Days Between Cycles: _____

Last Pap Exam _____

Results: ◯ Normal ◯ Abnormal ◯ Unsure

Have you recently experienced *(Circle all that apply)*: *heavy flow, light flow, no flow, spotting, pain, discharge, vaginal itching/burning, breast tenderness, breast lump(s), nipple discharge*

PMS Symptoms *(Circle all that apply)*: *pain, bloating, irritability, nausea, mood swings, constipation*

19. Additional info - *MEN ONLY* ♂

	Yes	No
Do you wake up in the night to urinate?	◯	◯
If yes, how many times? _____		
Blood in the urine?	◯	◯
Do you have pain or burning upon urination?	◯	◯
Has the force of urination decrease recently?	◯	◯
Do you have problems emptying your bladder completely?	◯	◯
Do you have penile blood or discharge?	◯	◯
Erectile Dysfunction?	◯	◯
Premature Ejaculation?	◯	◯
Pain or swelling in your testicles?	◯	◯

Last prostate exam: _____

Results: _____

20. Activities of Daily Living - *How does this condition interfere with your life and ability to function?*

	No Effect	Mild	Moderate	Severe
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

21. What is the primary stressor in your life? _____

22. How much sleep do you average per night? _____ **Hours**

23. What is the type and approximate age of your mattress and pillow? _____

24. What is your preferred sleeping position? ◯ Right side ◯ Back ◯ Left side ◯ Stomach

25. Describe your typical eating habits: ◯ Skips breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

26. What would be the most significant thing we could do to help improve your health? _____

_____

27. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

28. Would you like to learn more about: ◯ *chiropractic* ◯ *acupuncture* ◯ *massage therapy* ◯ *nutrition* ◯ *exercise*

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or causes of my health concern.

_____ *Signature*

_____ *Date (MM/DD/YYYY)*

If the patient is a minor child, print child's full name: _____

CONSULTATION NOTES

Patient Name _____

Patient Number *(Office Use Only)* _____

Doctor's Signature _____

Date _____