

# PERFECT BALANCE HEALTH CENTER

## STEP 1

### PERSONAL HISTORY

NAME:	DATE:	/	/
ADDRESS:			
CITY	STATE:		ZIP:
HOME PHONE #:	CELL #:		
WORK #:			
SOCIAL SECURITY #:			
BIRTH DATE:	/	/	AGE: SEX: M F
HEIGHT:			WEIGHT:
MARITAL STATUS: SINGLE MARRIED			SPOUSE'S NAME:
DRIVERS LICENSE #:	EXP DATE:		STATE:
EMAIL:			

In case of an emergency, who should we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### CONSENT TO CARE FOR A MINOR CHILD

I hereby authorize **Head, Hands and Heart Chiropractic and Wellness** to administer healthcare services as they deem necessary to my children.

Signature \_\_\_\_\_

### FEMALE PATIENTS ONLY

I declare that to the best of my knowledge I am not pregnant and I submit to spinal x-ray analysis for diagnosis of my condition. I will hold **Head, Hands and Heart Chiropractic and Wellness** harmless if I fail to report this information.

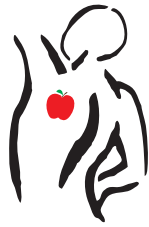
Signature \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

I am solely responsible for any changes or fees associated with my health care services, and I will be advised of all changes prior to execution of any services.

Signature \_\_\_\_\_

**PLEASE GIVE THE RECEPTIONIST A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARE (if insured) SO COPIES CAN BE MADE FOR YOUR FILE.**



# PERFECT BALANCE HEALTH CENTER

## STEP 2

In order for us to better serve you, please provide detailed answers to the questions below

1.) In your own words, what is the primary reason for coming to our office. (in detail)

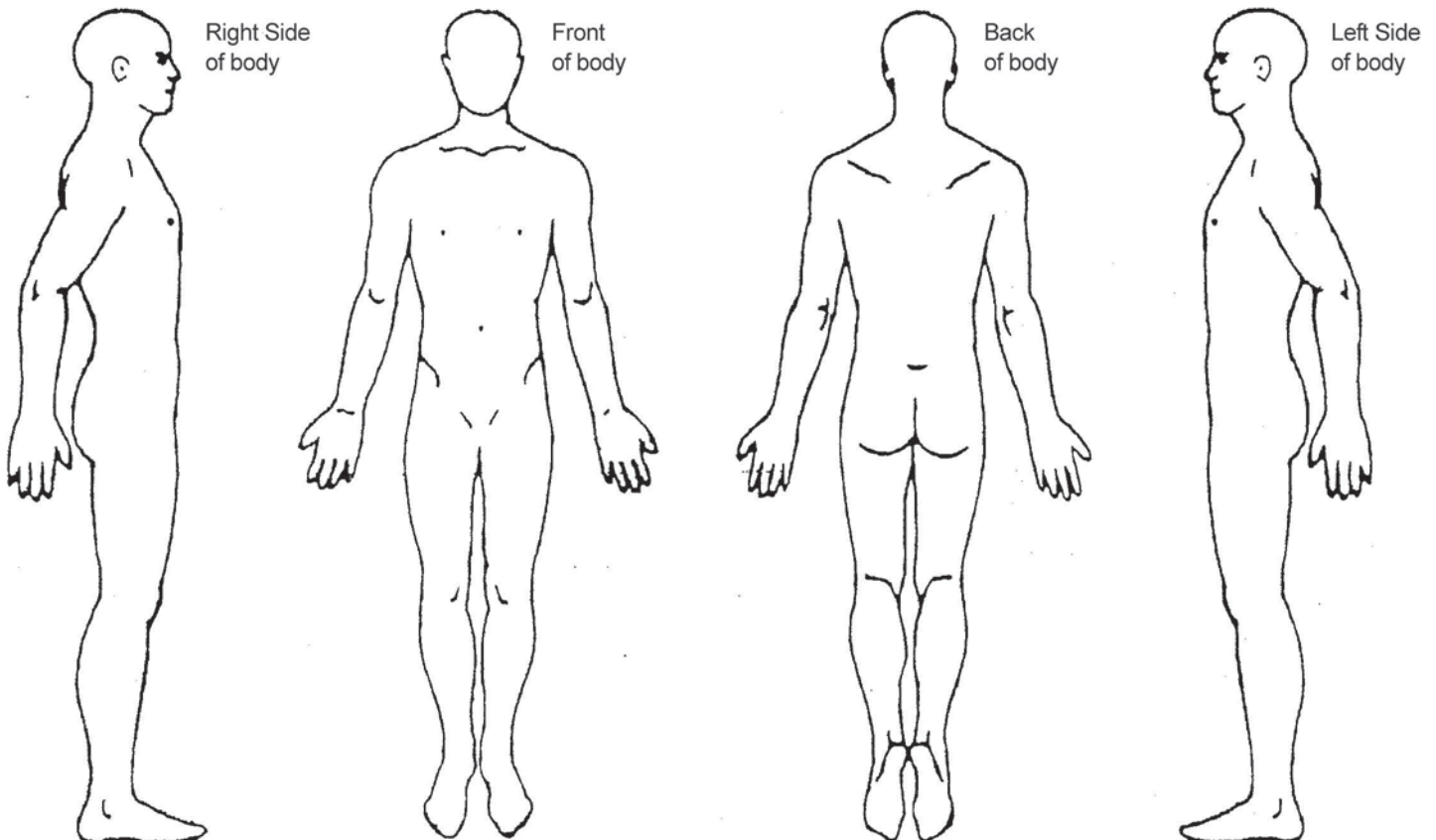
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2.) Please describe the location and sensations of your symptoms (in detail) (examples: Weakness, Tingling, Numbness, Pins and Needles, Burning, Aching, Stabbing, Shooting)

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3.) Please mark the area(s) of injury or discomfort on the illustration below using the appropriate symbols.

Description → Weakness      Tingling      Numbness      Pins & Needles      Burning      Aching      Stabbing      Shooting  
Use Symbol →  W       T       N       P       B       A       ST       SH  
Draw a circle  around any area of pain not represented by a symbol.



4.) On a scale from 0 to 10, grade the severity of each of the above symptoms separately. ("0" being no discomfort and "10" being extreme discomfort)

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5.) When did you first begin to notice the symptoms?

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6.) Have you ever had these symptoms before? ( When? How often? )

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## STEP 3

Please use the space provided to explain in detail any information to clarify any of the checked off conditions below.

Have You or any Family member had any of the following: (S for Self or F for family member)

- |  |   |
|--|---|
| <input type="checkbox"/> Bone Fractures of any Kind  | <input type="checkbox"/> Blood in Urine or Stool  |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Chest Pain   |
| <input type="checkbox"/> Skin or Rash problems   | <input type="checkbox"/> Heart conditions of Any Kind   |
| <input type="checkbox"/> Colds & Flu Shots   | <input type="checkbox"/> Emphysema or Asthma (circle one)   |
| <input type="checkbox"/> Seasonal Allergies or Allergic Reactions  | <input type="checkbox"/> Congestion or Pneumonia  |
| <input type="checkbox"/> Sinus or Ear Infection  | <input type="checkbox"/> Cancer of Any Kind   |
| <input type="checkbox"/> Menstrual cramps  | <input type="checkbox"/> Diabetes type 1 or 2 (circle one)  |
| <input type="checkbox"/> Pre-Menstrual Syndrome  | <input type="checkbox"/> Seizures, epilepsy   |
| <input type="checkbox"/> Hysterectomy  | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Hormone Imbalances  | <input type="checkbox"/> High/low blood pressure  |
| <input type="checkbox"/> Hormone Replacement Therapy   | <input type="checkbox"/> Liver conditions   |
| <input type="checkbox"/> Thyroid Condition   | <input type="checkbox"/> Gall bladder conditions  |
| <input type="checkbox"/> Enlarged Prostate   | <input type="checkbox"/> Kidney conditions  |
| <input type="checkbox"/> Impotence or loss of libido   | <input type="checkbox"/> Pregnancy (Prior)  |
| <input type="checkbox"/> Stomach Acid reflux or Esophageal Reflux  | <input type="checkbox"/> AIDS. HIV  |
| <input type="checkbox"/> Dizziness, Lightheadedness or Vertigo   | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Digestion Problems  | <input type="checkbox"/> Anxiety  |
| <input type="checkbox"/> Bleeding Ulcers or Bleeding Gastritis   | <input type="checkbox"/> ADD / ADHD   |
| <input type="checkbox"/> Urine or Stool Incontinence   | <input type="checkbox"/> Coughing, Sneezing, or Bowel Movements (with Pain)                             |
| <input type="checkbox"/> Diarrhea or Constipation  | <input type="checkbox"/> Daily Fatigue  |
| <input type="checkbox"/> Headaches (Tension, Stress. Hormonal)   | <input type="checkbox"/> Blood Disorders  |
| <input type="checkbox"/> Neck pain or stiffness  | <input type="checkbox"/> General Muscle Aches or pains  |
| <input type="checkbox"/> Numbness, Pain or Tingling in the shoulder,<br>arms, elbows, hands, or Fingers  | <input type="checkbox"/> Appendicitis   |
| <input type="checkbox"/> Numbness, Pain, or tingling in the buttocks,<br>thighs, knees, legs, feet, toes | <input type="checkbox"/> Unexplained Weight Loss or Gain  |
| <input type="checkbox"/> Coldness or Heat found in the Hands or Feet                                     | <input type="checkbox"/> Loss of smell or taste   |
| <input type="checkbox"/> Jaw pain (TMJ)  | <input type="checkbox"/> Ringing in Ears <span style="float: right;">Right    Left</span>               |
| <input type="checkbox"/> Mid back Pain or Stiffness  | <input type="checkbox"/> Loss of Hearing <span style="float: right;">Right    Left</span>               |
| <input type="checkbox"/> Low back Pain or Stiffness  | <input type="checkbox"/> Loss of vision, blurred <span style="float: right;">Right    Left</span>       |
|  | <input type="checkbox"/> Doubled vision <span style="float: right;">Right    Left</span>                |
|  | <input type="checkbox"/> Hip joint pain or replacement <span style="float: right;">Right    Left</span> |
|  | <input type="checkbox"/>  |

### Physicians Notes

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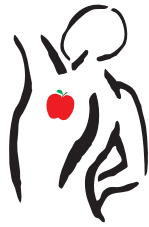
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# PERFECT BALANCE HEALTH CENTER

## STEP 4

In order for us to better serve you, please provide detailed answers to the questions below.

1.) Are the symptoms becoming more frequent? Yes No If "Yes", please explain.

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2.) Are the symptoms becoming more severe? Yes No If "Yes", please explain.

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3.) What activities make your symptoms worse. (e.g. lifting, bending, standing, walking etc.)

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4.) What activities make your symptoms better.

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5.) What time of day do your symptoms appear worse? Please describe. (e.g. morning, afternoon, evening)

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6.) Have you been treated by other Doctors for these symptoms? Yes No

Dr. Name: \_\_\_\_\_ date \_\_\_\_/\_\_\_\_/\_\_\_\_

TESTS \_\_ Blood Test \_\_ X-Ray / MRI \_\_ Lab Work \_\_ other \_\_\_\_\_

TREATMENT \_\_ Medications \_\_ Physical Therapies \_\_ other \_\_\_\_\_

Results of treatment: \_\_\_\_\_

Length of time under care: \_\_\_\_\_

7.) What types of Medications are you taking at this time?

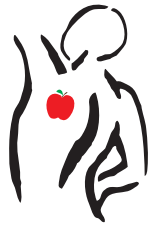
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8.) Do you take over-the-counter drugs? Yes No If "Yes", what do you usually take?

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# PERFECT BALANCE HEALTH CENTER

## STEP 5

In order for us to better serve you, please provide detailed answers to the questions below.

1.) How does your major complaint affect you at **work** ( when severe )?

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2.) How does your major complaint affect you at **home** ( when severe )?

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3.) How does your major complaint affect you at **recreationally** ( when severe )?

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