BODY IN BALANCE CHIROPRACTIC AND MEDICAL

CHIROPRACTIC REGISTRATION AND HISTORY

NAME:_____ SEX M F DATE:_____/_____/_____

ADDRESS:_____STATE_____ZIP_____

BEST PHONE_____EMAIL_____DATE OF BIRTH____/____/_____AGE_____

EMPLOYER_____OCCUPATION_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE BEFORE? YES NO IF YES, WHEN?_____

CHIEF COMPLAINT

REASON FOR VISIT_____

WHEN DID THE COMPLAINT BEGIN? HOW?_____

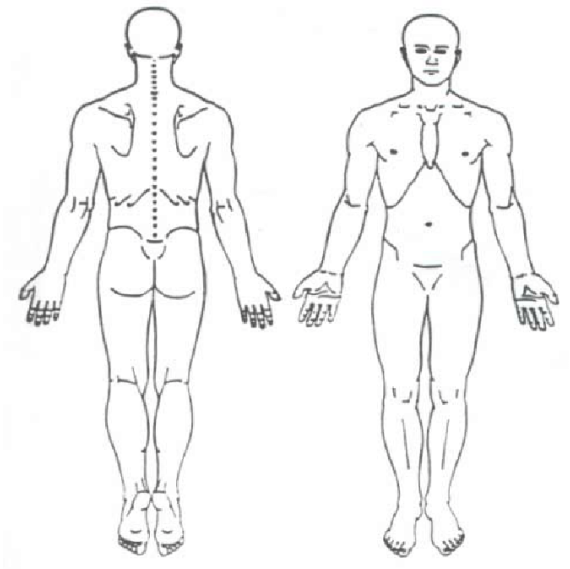
PLEASE CIRCLE THE QUALITY OF COMPLAINT/PAIN:

DULL ACHING SHARP SHOOTING BURNING THROBBING DEEP
NAGGING NUMBNESS SWELLING STIFFNESS TINGLING
OTHER_____

DOES THE COMPLAINT TRAVEL TO ANY OTHER AREAS OF THE BODY?
WHERE?_____

DO YOU HAVE NUMBNESS OR TINGLING IN YOUR BODY? WHERE?

_____



HOW FREQUENT IS THE PAIN? (PLEASE CIRCLE ONE):

CONSTANT FREQUENT INTERMITTENT OCCASIONAL SELDOM

GRADE OF INTENSITY/SEVERITY: (USE NUMBER SCALE BELOW)

(NO COMPLAINT/PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

DOES ANYTHING AGGRAVATE THE PAIN?_____

DOES ANYTHING MAKE THE PAIN BETTER?_____

ANYTHING ASSOCIATED WITH THE PAIN?_____

PREVIOUS TREATMENTS, MEDICATIONS, SURGERY, OR CARE FOR YOUR COMPLAINT

ICE: YES NO DID IT HELP?_____ HEAT: YES NO DID IT HELP?_____ STRETCHING: YES NO DID IT HELP?_____

OVER THE COUNTER MEDICATIONS:_____DID THEY HELP?_____

OTHER: (PHYSICAL THERAPY, MASSAGE, ACUPUNCTURE, PRECRIBED MEDICATIONS, ETC):

_____

SURGERY?_____ PHYSICAL THERAPY?_____

NAME OF DOCTORS WHO HAVE TREATED YOU BEFORE:_____

PAST HEALTH HISTORY

DATE OF LAST:

PHYSICAL:_____BLOOD TEST:_____IMAGING:_____

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PLEASE PLACE AN X ON THE YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

DISEASE/CONDITION	YES	NO	DISEASE/CONDITION	YES	NO	DISEASE/CONDITION	YES	NO
Chicken Pox			Parkinson's disease			Rheumatoid Arthritis		
Measles			Multiple Sclerosis			Herniated disc		
Whooping Cough			Migraine headaches			Gout		
Ear Infections			Thyroid disorders			Hernias		
Mumps			Ulcers			Headaches		
Scarlet Fever			Heartburn			Arthritis		
Rheumatic Fever			Asthma			Liver Disease		
Tonsilitis			Bronchitis			Hepatitis		
Cardiac Arrhythmias			Pneumonia			High Cholesterol		
Blood Clots			Bulimia/Anorexia			HIV/AIDS		
Heart Disease			Depression			Vaginal Infections		
Varicose Veins			Anxiety			Mononucleosis		
Bleeding Disorders			Psychiatric Care			Herpes		
Stroke			Chemical Dependency			Tumors/Growths		
High Blood Pressure			Suicide Attemps			Cancer		
Anemia			Alcoholism			Breast Lump		
Prostate Disorders			Miscarriage			Pregnant		

OTHER:_____

_____

BROKEN BONES?_____

CONCUSSIONS?_____

CAR ACCIDENTS?_____

FALLS?_____

ALLERGIES

ALLERGY	REACTION

MEDICATIONS

MEDICATION	REASON FOR TAKING	DOSE

SUPPLEMENTS

SUPPLEMENT	BRAND

SURGERIES

SURGERY:	DATE:

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FEMALE ONLY

PREGNANCY/DATE OF DELIVERY	OUTCOME

WHAT WA THE DATE OF THE BEGINNING OF YOUR LAST MENSTRUAL CYCLE?_____

DATE OF LAST PAP SMEAR:_____

FAMILY HEALTH HISTORY

FAMILY HISTORY OF:

DISEASE/CONDITION	FAMILY MEMBER	IF DECEASED, AGE OF DEATH:
HEART DISEASE		
CANCER		
DIABETES		
STROKE		
NEUROMUSCULAR DISEASE (ALS, ETC)		
DEMENTIA/ALZHEIMERS		
OTHER		

SOCIAL AND OCCUPATIONAL HISTORY

JOB DESCRIPTION:_____

HOW MANY HOURS A DAY DO YOU SIT?_____

RECREATIONAL ACTIVITIES:_____

LIFESTYLE (HOBBIES, LEVEL OF EXERCISE, ALCOHOL USE, AND DRUG USE, DIET):_____

_____

DAYS THAT WORK BEST WITH YOUR SCHEDULE: M T W TH F S

SMOKER: YES NO IF YES, HOW MANY PACKS PER DAY?_____NUMBER OF YEARS AS A SMOKER_____

GOALS

HEALTH GOALS YOU WOULD LIKE TO DISCUSS FURTHER WITH YOUR DOCTOR:

1. _____
2. _____
3. _____

INFORMED CONSENT

I HAVE READ THE ABOVE INFORMATION AND CERTIFY IT TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE, AND HEREBY AUTHORIZE THIS OFFICE OF CHIROPRACTIC AND MEDICAL TO PROVIDE ME WITH THE CARE I NEED IN ACCORDANCE WITH THIS STATE'S STATUTES.

PATIENT OR GUARDIAN SIGNATURE_____DATE_____