Balanced Chiropractic

Welcome!

Please read the following…

What to expect:

First Visit- • consultation • chiropractic exam • specific x-ray series

Second visit- • 2 more specific x-rays • doctor's report of findings • first specific chiropractic adjustment given • treatment plan for initial intensive care given • sign up for health care class.

Patient Information

Name_________________________________Date_____________Age___ Sex___ Birth Date_______________

Address____ City___________________ Zip Code____________

Home (____)__________________ Cell (____)________________ Email________________________________

Employer_______________________________________ Marital Status S M D W

Spouse/Emergency contact____________________________________Phone (____)_______________________

Who referred you to our office?____

Health History

Description of primary health concern(s):

____

____

When (# of months or years ago) did you first start experiencing this issue ___________________________________

Why did this begin?____

____

What makes the condition: Better_____________________________Worse______________________________

At Balanced Chiropractic we are **very committed** to bringing out the bodies **full expression of health.**

How committed are you to your health?

1 2 3 4 5 6 7 8 9 10

I just want to feel good

I realize Health is most important

2464 West 12600 South
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Review of Systems

-Check all that apply-

Musculo-Skeletal System
- O Headaches
- O Migraines
- O Arm/ hand pain
- O Leg/ foot pain
- O Neck pain
- O Mid-back pain
- O Low back pain

Respiratory System
- O Asthma
- O Frequent colds
- O Sinusitis
- O Frequent coughing

Reproductive System (Men)
- O Testicular pain
- O Erectile Dysfunction
- O Prostate problems

Reproductive System (Women)
- O Abundant menses
- O Menstrual pain
- O Menopause/ pre symptoms

Touch & Sensations
- O Numbness
- O Dizziness
- O No sensation in a limb
- O Tremors

Cardiovascular System
- O Low blood pressure
- O High blood pressure
- O Chest pain
- O Fainting
- O Short breath

Blood Abnormalities
- O High Cholesterol
- O Anemia

Wellness
- O Depression
- O Fatigue
- O Insomnia

Hearing
- O Ringing in ears
- O Clogged ears

Sight
- O Blurred vision

Digestive System
- O Bloating/gas
- O Diarrhea
- O Constipation
- O Heartburn
- O Ulcers

Urinary System
- O Kidney Stones
- O Frequent urge to urinate

Cancer
- O Intestinal
- O Ovarian
- O Prostate
- O Lung
- O Breast
- O Uterine
- O Other__________

Psychological Imbalances
- O Alcoholism
- O Anorexia/ Bulimia
- O Drug dependence
- O Psychiatric care
- O Suicide Attempt

Endocrine System
- O Hypoglycemia
- O Diabetes
- O Thyroid
- O Other_____________

Chronic Diseases
- O Rheumatoid Arthritis
- O Emphysema
- O Seizures
- O Fibromyalgia
- O Goiter
- O Hepatitis
- O Chronic Fatigue Syndrome
- O Herniated disc
- O Osteoporosis
- O Parkinson's
- O Multiple Sclerosis

Lifestyle

1. Do you smoke? ☐ Everyday ☐ Occasionally ☐ Never
2. Do you drink alcohol? ☐ Everyday ☐ Occasionally ☐ Never
3. How many hours of sleep do you normally get? ☐ 6-8 ☐ 8-10 ☐ 10 or more
4. How would you rate your stress level? ☐ Very stressed ☐ Stressed ☐ Slightly stressed ☐ No stress

Accidents & Traumas

1. Have you ever been in a car accident? ☐ Never ☐ 1-2 accidents ☐ 3+ accidents
2. Have you ever had a work injury? ☐ Never ☐ 1-2 injuries ☐ 3+ injuries
3. Did you ever have an injury to your neck or back? ☐ Never ☐ 1-2 injuries ☐ 3+ injuries
4. Have you ever had a concussion or blow to the head? ☐ Never ☐ 1-2 injuries ☐ 3+ injuries

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