# Patient Introduction

Date ____________________

Name ____________________

Address ____________________

City ____________________

State ____________ Zip ____________

Cell phone ____________________

Home phone ____________________

Work phone ____________________

E-mail address ____________________

Gender: □ Male □ Female

Date of Birth ____________ Age ________

Soc Sec No. ____________________

□ Single □ Married □ Divorced □ Widowed

Name of spouse (or parent) ____________________

Number of children ____________________

Occupation ____________________

Employer ____________________

Work address ____________________

City ____________________

State ____________ Zip ____________

Emergency contact ____________________

Relationship ____________________

Phone ____________________

Referred by ____________________

Have you ever been treated by a chiropractor before?

□ No □ Yes If yes, when? ____________________

Name of family physician ____________________

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**INSURANCE INFORMATION:**

Name of Insurance Carrier/Medicare____________________

Policy Holder ____________________ Relationship to Patient ____________________

Policy No. ____________________ Group No.____________________

Are you seeking care for injuries sustained in an accident? □ Yes □ No

Type of accident: □ Auto □ Work □ Home □ Other ____________________

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Purpose of this appointment ____________________

Other doctors seen for this condition/problem ____________________

Have you been treated for any health problem(s) by a physician this year? □ Yes □ No

Describe ____________________

Any additional information we need to know ____________________

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Balance Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Balance Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services provided for me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services provided for me will be immediately due and payable.

Signature ____________________
(if patient is a minor, name of parent or guardian)

# Patient History

The following is a confidential questionnaire which will help us determine the best course of treatment for you. Please take your time and complete the information accurately. Thank you!

Please check the box that indicates your symptoms by using the following codes:

N—Never had P—Previously had C—Currently have

□ N □ P □ C Headaches ____________________

□ N □ P □ C Neck Problems ____________________

□ N □ P □ C Pain Between Shoulderblades ____________________

□ N □ P □ C Low Back Pain ____________________

□ N □ P □ C Arm Problems ____________________

□ N □ P □ C Leg Problems ____________________

□ N □ P □ C Swollen Joints ____________________

□ N □ P □ C Painful Joints ____________________

□ N □ P □ C Stiff Joints ____________________

□ N □ P □ C Sore Muscles ____________________

□ N □ P □ C Weak Muscles ____________________

□ N □ P □ C Walking Problems ____________________

□ N □ P □ C Ruptures ____________________

□ N □ P □ C Broken Bones ____________________

□ N □ P □ C Numbness ____________________

□ N □ P □ C Loss of Feeling ____________________

□ N □ P □ C Paralysis ____________________

□ N □ P □ C Dizziness ____________________

□ N □ P □ C Fainting ____________________

□ N □ P □ C Muscle Jerking ____________________

□ N □ P □ C Forgetfulness ____________________

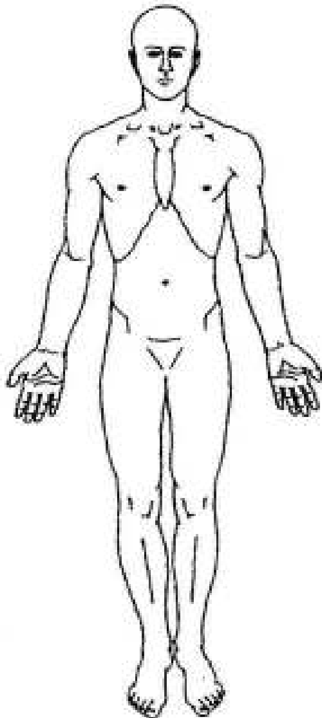
□ N □ P □ C Convulsions ____________________

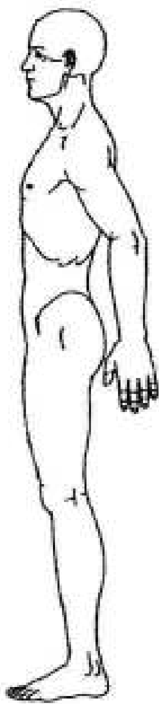
□ N □ P □ C Confusion ____________________

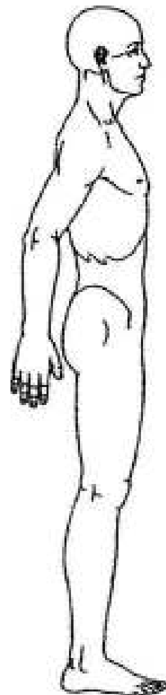
□ N □ P □ C Depression ____________________

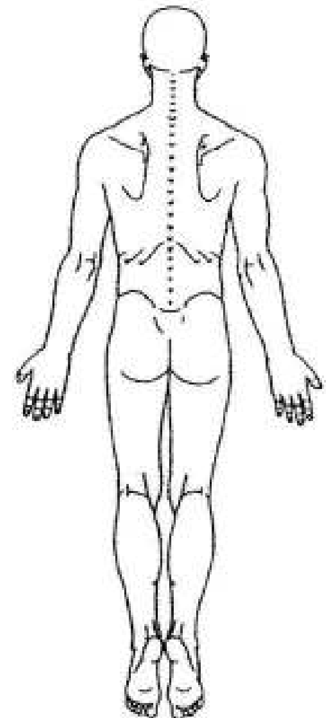
Mark the areas on the figures below where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

| Numbness | Dull Ache | Hot burning | Sharp Stabbing | Pins & Needles |
|---|---|---|---|---|
| === | 000 | XXX | /// | +++ |









Balance Chiropractic 133 W. Lemon Ave., Monrovia, CA 91016 Tel: (626) 357-2222 Fax: (626) 605-5155 www.bal-chiropractic.com

Please list all your past accidents, injuries, surgeries, and hospitalizations

______________________________ Date or Age ______________
______________________________ Date or Age ______________
______________________________ Date or Age ______________
______________________________ Date or Age ______________
______________________________ Date or Age ______________

What medications, vitamins, supplements, herbs do you take?

| **Name** | **Reason** |
| --- | --- |
| | |
| | |
| | |
| | |

Please list any allergies that you have

______________________________

Do you or other family members have a history of any of the following?

| | | |
| --- | --- | --- |
| Arthritis | □ Self | Family member ______________ |
| Asthma | □ Self | Family member ______________ |
| Cancer | □ Self | Family member ______________ |
| Diabetes | □ Self | Family member ______________ |
| Heart Disease | □ Self | Family member ______________ |
| Hypertension | □ Self | Family member ______________ |
| Hypoglycemia | □ Self | Family member ______________ |
| Kidney Disease | □ Self | Family member ______________ |
| Depression | □ Self | Family member ______________ |
| Mental Illness | □ Self | Family member ______________ |

Do you drink coffee or black tea? ______________ If so, how much per day? ______________

Do you smoke tobacco? ______________ If so, how much per day? ______________

Do you drink alcohol? ______________ If so, how often? ______________

How many times a week do you engage in physical activity that is sufficiently prolonged and intense to cause sweating and raise your heart rate?______________

When you engage in the physical activity noted above, what is the average duration of activity?

____ Less than 10 minutes ____ 10 – 20 mins ____ 20 – 30 mins ____ 30 – 60 mins _____ 60+ mins

When you engage in the physical activity noted above, what do you feel the level of effort is?______________

At work, how many days per week do you engage in tasks that are intense enough to cause sweating and a rapid heart rate?______________

Please rate your level of fitness (0 = very poor, 5 = average, 10 = excellent) ______________