

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name First Name M. I.

Address _____

City _____ State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

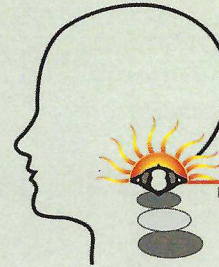
Relationship _____

Home Phone (____) _____

Work Phone (____) _____

INSURANCE

CHIROPRACTIC IS
 HEALTH INSURANCE
 PREMIUMS SMALL
 DIVIDENDS LARGE



**Balanced
 SPINE CENTER**
 UPPER CERVICAL CHIROPRACTIC

Balanced Spine Center does not accept insurance but we will be happy to provide proper documentation for you to submit to your insurance provider for reimbursement.

Our services are provided with cash / credit card only.

Balanced Spine Center is not responsible for our patient's financial life—only HEALTH life.

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

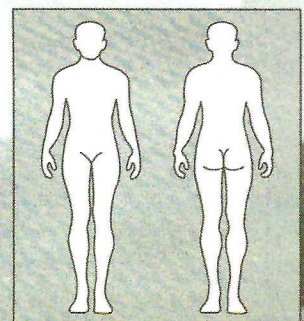
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|--|---|--|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Herniated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ |

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking _____ Packs/Day
 Alcohol _____ Drinks/Week
 Coffee/Caffeine Drinks _____ Cups/Day
 High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____