BACK INTO BALANCE — New Patient Intake Form (Page 1 of 3)

HOW CAN WE SERVE YOU?

Subluxations (spinal misalignments) cause most of the unwanted health conditions people suffer from every day.

Have you had an auto accident? ☐ Yes ☐ No If yes, number of accidents and year(s)_____

☐ I have no complaints. I am here for a wellness check up. **Date of Birth:**_____

Have you had Chiropractic care before? ☐ No ☐ Yes Year?_____ Where?_____

Have you had Spinal Surgery? ☐ **Yes** ☐ **No When**?_____ **Was METAL inserted?** ☐ **Yes** ☐ **No** Where?_____

YOUR HEALTH CONCERNS:

1) What is your **FIRST** health concern?_____

2) When did you first notice this health concern?_____

3) Does this problem ☐ stay in one area OR ☐ radiates/travels to my _____

4) Is this pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Aching ☐ Numbness

5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? ☐ Yes ☐ No

6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10

7) Is your condition: ☐ Episodic ☐ Frequent ☐ All the time

8) What treatments have you already tried to help with this condition?_____

_____

9) For this problem have they performed: ☐ MRI ☐ CT ☐ X-Ray ☐ Surgery ☐ Other_____

10) How has this health concern affected your activities and your life?_____

_____

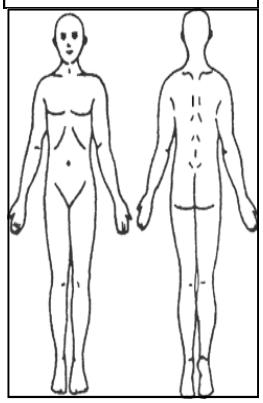
11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years

_____

12) Notes:_____

_____

Mark the area of your **FIRST** concern.



1) What is your **SECOND** health concern?_____

2) When did you first notice this health concern?_____

3) Does this problem ☐ stay in one area OR ☐ radiates/travels to my _____

4) Is this pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Aching ☐ Numbness

5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? ☐ Yes ☐ No

6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10

7) Is your condition: ☐ Episodic ☐ Frequent ☐ All the time

8) What treatments have you already tried to help with this condition?_____

_____

9) For this problem have they performed: ☐ MRI ☐ CT ☐ X-Ray ☐ Surgery ☐ Other_____

10) How has this health concern affected your activities and your life?_____

_____

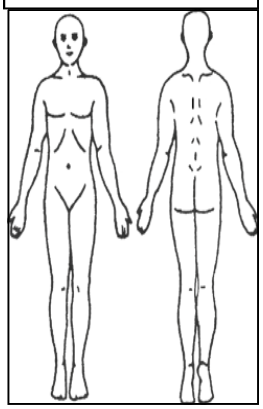
11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years

_____

12) Notes:_____

_____

Mark the area of your **SECOND** concern.



Office Use Only

	Pre	Post
Leg Check		
Anatometer		
Shoulder		
Hip		
Thermography		

KVP: 76 MA:120	**Lat: T:**____	**Nas: S:**_____ **E:**_____ **T:**_____ **Rot:**_____	**Vertex: T:**_____ **Neck:**_____

Degeneration Phase: _____

Total #_____

Time: _____

Source:_____

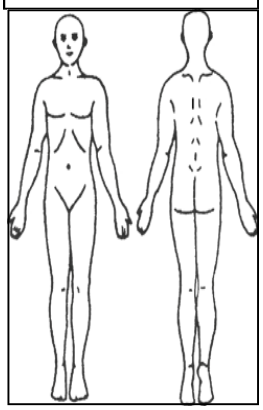
Therapy Code:_____ Schedule:_____

Spouse:_____

Name: ID# DOB: Date:

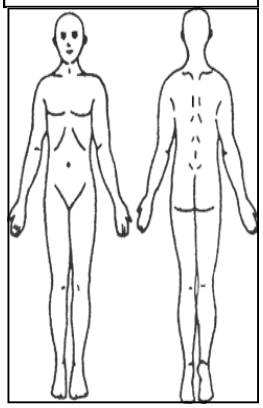
1) What is your **THIRD** health concern?_____
2) When did you first notice this health concern?_____
3) Does this problem ☐ stay in one area OR ☐ radiates/travels to my _____
4) Is this pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Aching ☐ Numbness
5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? ☐ Yes ☐ No
6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
7) Is your condition: ☐ Episodic ☐ Frequent ☐ All the time
8) What treatments have you already tried to help with this condition?_____
_____
9) For this problem have they performed: ☐ MRI ☐ CT ☐ X-Ray ☐ Surgery ☐ Other_____
10) How has this health concern affected your activities and your life?_____
_____
11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years
_____
12) Notes:_____
_____

Mark the area of your **THIRD** concern.



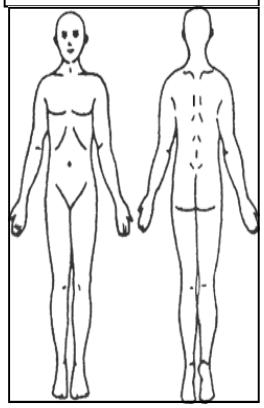
1) What is your **FOURTH** health concern?_____
2) When did you first notice this health concern?_____
3) Does this problem ☐ stay in one area OR ☐ radiates/travels to my _____
4) Is this pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Aching ☐ Numbness
5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? ☐ Yes ☐ No
6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
7) Is your condition: ☐ Episodic ☐ Frequent ☐ All the time
8) What treatments have you already tried to help with this condition?_____
_____
9) For this problem have they performed: ☐ MRI ☐ CT ☐ X-Ray ☐ Surgery ☐ Other_____
10) How has this health concern affected your activities and your life?_____
_____
11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years
_____
12) Notes:_____
_____

Mark the area of your **FOURTH** concern.



1) What is your **FIFTH** health concern?_____
2) When did you first notice this health concern?_____
3) Does this problem ☐ stay in one area OR ☐ radiates/travels to my _____
4) Is this pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Aching ☐ Numbness
5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? ☐ Yes ☐ No
6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
7) Is your condition: ☐ Episodic ☐ Frequent ☐ All the time
8) What treatments have you already tried to help with this condition?_____
_____
9) For this problem have they performed: ☐ MRI ☐ CT ☐ X-Ray ☐ Surgery ☐ Other_____
10) How has this health concern affected your activities and your life?_____
_____
11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years
_____
12) Notes:_____
_____

Mark the area of your **FIFTH** concern.



Please indicate any MAJOR health concerns you are experiencing

NEUROLOGICAL CODE
☐ Headaches
☐ Numbness/Tingling
☐ Loss of Balance
☐ Paralysis
☐ Dizziness
☐ Depression
☐ Fainting

GENERAL CODE
☐ Fatigue/Low Energy
☐ Allergies/Hay Fever
☐ Loss of Sleep/Trouble Sleeping

EENT CODE
☐ Vision Problems
☐ Dental Problem
☐ Sore Throat
☐ Earache
☐ Hearing Difficulty
☐ Sinus Trouble
☐ Loss Of Smell
☐ Loss Of Taste
☐ Ringing In Ears

GASTRO-INTESTINAL CODE
☐ Poor/Excessive Appetite
☐ Frequent Nausea/Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Abdominal Cramps
☐ Gas/Bloating After Meals
☐ Ulcers

GENITO-URINARY CODE
☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Kidney Trouble

CARDIOVASCULAR CODE
☐ Chest Pain
☐ Shortness of Breath
☐ High Blood Pressure
☐ High Cholesterol
☐ Irregular Heartbeat
☐ Lung Problems/Congestion
☐ Ankle Swelling
☐ Stroke
☐ Asthma

FEMALES ONLY
☐ Menstrual Irregularity
☐ Menstrual Cramps
☐ Vaginal Pain/Infection
☐ Breast Pain/Lumps

To determine if x-rays can be safely performed, when was your last period?_____

Are you pregnant? ☐ Yes ☐ No
Menopausal? ☐ Yes ☐ No

MALES ONLY
☐ Prostate Problems
☐ Erectile/Sexual Dysfunction (ED)

OTHER HEALTH CONCERNS NOT LISTED

_____

_____

FAMILY HISTORY
The following members of my family have the same or similar problems:
☐ Mother ☐ Father
☐ Brother ☐ Sister
☐ Spouse ☐ Child

INSURANCE INFORMATION

Insurance Company_____
Medicare ☐ Yes ☐ No Is Medicare: ☐ Primary ☐ There is a supplemental
☐ I transferred my Medicare to another insurance company. The insurance company is now primary.

OTHER INFORMATION

Height:_____ Weight:_____
Emergency Contact:_____Phone Number:_____

CONSENT TO EXAMINATION; PLEASE READ AND SIGN BELOW

I hereby authorize the Doctor to examine my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays is for the information only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office or forwarded to another health care provider for review and to be returned in 30 days.

*Patient's Name (Print):*_____*Patient's Signature:*_____ *Date:*_____
Guardian or Spouse's Signature to treat Minor: _____ *Date:*_____

CANCELLATION AND NO-SHOW POLICY; PLEASE READ AND SIGN BELOW

Please be courteous to all other patients that are consulting our office. Your appointment is reserving a 30 minute block of time with the doctor when **no other patients are being scheduled**. Please give our office at **LEAST a 48 hour notice** of any needed changes to your appointment.

*Patient's Signature:*_____ *Date:*_____

OFFICE USE ONLY Name: ID#