Welcome to

Balanced Living
CHIROPRACTIC WELLNESS
Patient Entrance Data

Please print Today's Date ____/____/________

Name: (*last*) ____________________________ (*first*) ______________________ (*mi*) ________

Address: ____ Apt# ________

Zip: ______ City: ________________________ State: ____ BirthDate:___/___/____ Age: _____

Phone: Home:(_____) _____________ Work (_____) ___________ Cell: (____) ____________

SS# ______/_____/_________ email address: ______________________________________

How did you hear about us? □ Phone Book □ Live/Work Nearby □ Spinal Screening □ Website

□ Advertisement ______________________ □ Current/Former Patient ______________________

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed # Children: _____

Person to contact in case of emergency: ____

Relationship: ____ Phone: (_____) ______________

Spouse's Name: ______________ Children's Name(s): ___________________________________

Height: _________ Weight: ________ Blood Pressure: _______ Native Language: ____________

Handedness: □ Right □ Left □ Ambidextrous

Race: □ White □ Black □ Hispanic □ Asian □ Other _______________________

Highest Level Completed: □ Elementary □ H.S. □ Under Grad □ Post Grad □ Prof. School

Occupational History: *current or most recent first*

type of job/position	***# years***	***job activities***	***job related stresses***

Current Employer: ____

Address: __________________________ City: ___________________ St: ____ Zip: ___________

Hours of Sleep per Night: ___________ Quality of Sleep: □ Good □ Fair □ Poor

Physical Activities/Hobbies	***Frequency***

Last MD/Healthcare Provider: ____

Address: _______________________________City: ____________________ St: ____Zip_______

Phone ____________Date of last visit: __________ Reason: _______________________________

Previous Chiropractor: ____

Address: ________________________________ Phone: ____________Date of last visit: _________

Reason: _____________________________ Were X-Rays taken? Y N Date ____/____/______

Why are you seeking Chiropractic Care? ____

What is your Major Health Concern? ____

When did it start? ____/____/______ It started □ suddenly □ gradually

Duration of problem/episode? □ ______minutes □ ______hours □ ______days

□ ______weeks □ ______months □ ______years

Does this interfere with your □ work □ sleep □ daily activities

What do you think brought on your condition? ____

What makes it feel worse? _______________________ better? ____________________________

Other Healthcare Providers seen for this condition: ____
Were you advised to restrict any activities? □ yes □ no
If yes, explain ____

Describe your condition: (*check all that apply*) □ Constant □ Comes & Goes
□ Mild □ Moderate □ Severe □ Chronic □ Acute □ Localized □ Radiating
□ Numb □ Dull □ Burning □ Sharp □ Chronic □ Nagging □ Cramping □ Diffuse
□ Ache □ Pins & Needles □ Other ____________________________

Do you have difficulty: *check all that apply*
□ Sitting □ Standing □ Bending □ Walking □ Lifting □ Reaching
□ Turning □ Driving □ Reading □ Exercising/Sports

Is this related to a □ work or □ auto accident? □ Yes □ No

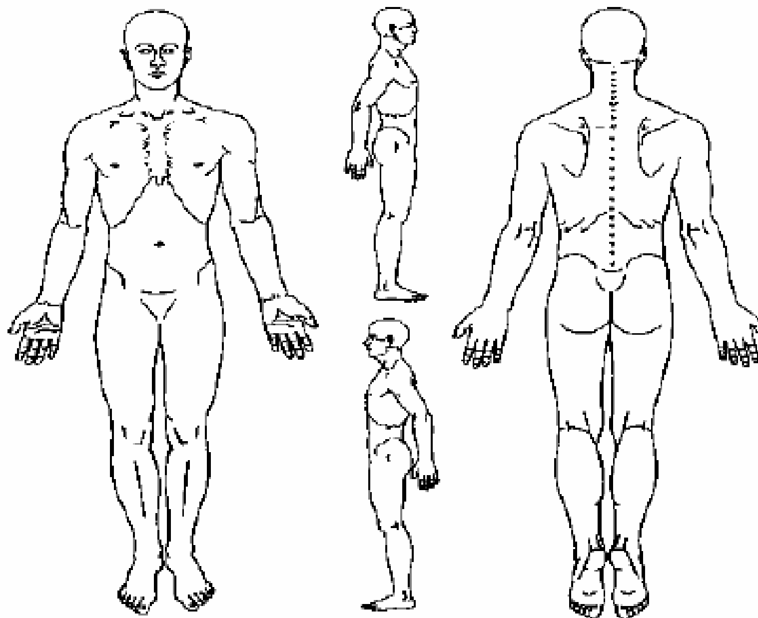
Has this been reported? □ Police □ Job Supervisor ________________________________

Are you in litigation for any accidents? □ Yes □ No Lawyer Name _______________________

Address _____________________________ City_______________________ Phone ____________

Circle any areas where you have problems and place the corresponding letter describing the type of pain

Type of Pain
A = Ache
S = Stabbing
N = Numb
B = Burning
P = Pins & Needles



Balanced Living Chiropractic

Case History

Patient Name: __________________________________ #: ____________ Date: ____/____/______

Thank you for completing this detailed health history. Please check each individual answer that applies and provide additional information where indicated. Include both ***past*** and ***present*** conditions. If you are not sure what a question means, please review with the doctor.
*Please provide physician information at bottom for all conditions for which you are under care.

Family History *(Relation)*

- □ Diabetes ________________
- □ Thyroid Disease___________
- □ Tuberculosis_____________
- □ Kidney Disease___________
- □ Blood Pressure ↑ ↓________
- □ Heart Disease____________
- □ Cancer _________________
  *type:*_____________________
- □ Stroke__________________
- □ Other __________________
  ____
  ____
  ____

Patient's General Health

- □ Recent weight change
  ↑ ↓ How much? ______lbs
  Why? _____________
- □ On-going fever/chills
- □ Periodic unexplained sweats
- □ Reoccurring allergies
- □ Anemia
- □ Bleeding/bruising
- □ Malaise/fatigue/weakness
- □ HIV positive
  - with/without symptoms
  Date:_________________
- □ Cancer - specify type:
  ____
  ____

Endocrine System

- □ Heat/Cold Intolerance
- □ Thyroid problems
- □ Diabetes
  - *Insulin dependent*
  -*Non-insulin dependent*
- □ Neck surgery/Irradiation
- □ Other glandular problems
  specify: _______________
  ____

Eyes/Ears/Nose/Throat

- □ Visual problems
- □ Corrective lenses
- □ Redness/tearing/itching
  - □ Due to allergies?
- □ Pain in eyes
- □ Glaucoma
- □ Detached Retina
- □ Other eye problems_______
- □ Difficulty hearing/deafness
- □ Ringing in ears/Dizziness
- □ Any change in ability to hear
- □ Ear growths/discharge
- □ Ear pain
- □ Nosebleeds
- □ Change in ability to smell
- □ Sneezing
- □ Nose growths/discharge
- □ Nose pain
- □ Sinus infection
- □ Other nose problems
- □ Hoarseness
- □ Change in voice
- □ Difficulty chewing/swallowing
- □ Enlarged/painful glands
  where? _______________
- □ Change in ability to taste
- □ Lesions in mouth/throat
- □ Dental problems
- □ Other throat/mouth problems

Urinary System

- □ Frequent urination
  # times/day ____ #/night ____
- □ Increased thirst
  Daily fluid intake: __________
- □ Urinary urgency/pain
- □ Change in urine (color, blood)
- □ Difficulty in holding urine
- □ Urethral discharge
- □ Urinary tract infections
- □ Kidney disease/stones
- □ Mid/back/flank (side) pain
- □ Pelvic pain or mass
- □ Other genitourinary problems
  specify: _________________

Gastrointestinal System

- □ Change in appetite
- □ Food Intolerance
- □ Nausea/Vomiting
- □ Vomiting of blood
- □ Peptic Ulcer
- □ Indigestion/Heartburn
- □ Abdominal pain (stomach)
- □ Abdominal swelling
- □ Abnormal flatulence (gas)
- □ Change in bowel habits/stool
  (frequency, color, consistency)
- □ Diarrhea
- □ Hernia
  □ Hiatal □ Femoral □ Inguinal
  Diagnosed by: _____________
  Date: __________
  Surgery? Y N Date: _____
- □ Hemorrhoids
- □ Gallbladder Surgery: Y N
- □ Liver disease Type: ________
- □ Pancreas
- □ Alcohol intake
  *type:*________*amount:*_______
- □ Other Digestive problems
  specify: __________________

Pulmonary System

- □ Difficulty breathing
- □ Cough
- □ Cough up blood
- □ Wheezing/Asthma
- □ Tuberculosis/exposure
  TB test or X-Ray Date: ____
- □ Respiratory infections
- □ Pneumonia
- □ Tobacco Use: past/present
  Cigarette / Cigar / Pipe / Chew
  #/day: ______ # years: ______
- □ Exposure to hazardous fumes, chemicals or excessive pollution
  type: ___________________
  amount: __________________
  duration: _________________
- □ Other pulmonary problems
  specify: _________________

Condition____________Physician__________________Address_______________________Phone_______
Condition____________Physician__________________Address_______________________Phone_______
Condition____________Physician__________________Address_______________________Phone_______

Cardiovascular
- □ Shortness of breath from exercise? Y N
  time of day ________________
  how often ________________
- □ Chest discomfort/pain
  type: ____________________
  how often: ________________
- □ Palpitations
- □ Edema
  type: ____________________
- □ Fainting
- □ Calf pain while walking
  how often: ________________
  relieved with rest: Y N
- □ High Blood Pressure
  medication to control? Y N
- □ Past heart disease
  type: ____________________
- □ Rheumatic fever
- □ Other heart problems
  *specify:*___________________

Neurological System
- □ Headaches
  where? ___________________
  how often? ________________
- □ Epileptic seizures
- □ Tics/Involuntary twitches/ Spasms
- □ Dizziness/Fainting
- □ Sensory disturbances (numbness / tingling)
- □ Unusual weakness
- □ Head Trauma
  type: _____________________
  date: _____________________
- □ Stroke
  type: ________________
  date: ________________
- □ Vertebral disc herniation
  level____________________
- □ Other neurological problems
  *specify*___________________

Breasts (Male & Female)
- □ Breast lumps/mass/growths/ pain/tenderness
- □ Dimples in breast
- □ Change in color/size/shape
- □ Nipple discharge/bleeding
- □ Other breast problems

Reproductive System
- □ Genital lesions
- □ Genital mass/growths/pain
- □ Other reproductive problems

Skin/Hair/Nails
- □ Change in skin texture
- □ Change in skin temperature
- □ Excessive dryness/perspiration
- □ Unusual skin coloration
- □ Rashes/itching/lesions
- □ Skin growths
- □ Mole changes
- □ Skin cancer
  location: _________________
- □ Skin pain
  location: _________________
- □ Change in hair texture/condition
- □ Change in hair growth/loss
- □ Change in shape of nails fingers/toes
- □ Change in color/condition of nails fingers/toes
- □ Other skin or hair problems

Musculoskeletal System
- □ Joint stiffness
- □ Change in range of motion
- □ Joint pain
- □ Joint swelling
- □ Muscle cramps
- □ Muscle weakness
- □ Muscle wasting
- □ Neck pain
- □ Upper back pain
- □ Mid back pain
- □ Low back pain
- □ Buttock pain
- □ Shoulder pain
- □ Arm/hand pain Left / Right
- □ Leg/foot pain Left / Right
- □ Fractures/dislocations/sprains
  specify _____________________
  ____
- □ Other injuries or accidents (auto, sports, work, etc.)
  specify w/date _______________
  ____
  ____
  ____
- □ Other musculoskeletal problems
  specify _____________________
  ____
  ____

Psychological History
- □ Anxiety
- □ Depression
- □ Hospitalized for care
- □ Other psychological problems
  specify _____________________
  ____

Hospitalizations/Medications
- □ Past hospitalizations?
  *specify w/ dates*______________
  ____
  ____
  ____
  ____
  ____
- □ Current medications: Prescribed. Over-the-Counter or Recreational
  ____
  ____
  ____
  ____
  ____
  ____
  ____
  ____

Diet/Exercise
- □ Do you eat a healthy diet?
- □ Have you an unusual appetite?
  □ large? □ small?
- □ Consume caffeine?
  _________/day or week
- □ Consume alcohol?
  _________/day or week
- □ Eat junk food regularly?
  ________/day or week
- □ Are you on a special diet?
  specify ____________________
  how long __________________
- □ Current dietary supplements
  ____
  ____

Implants/Orthopedic Supports
- □ Breast Implants
- □ Cardiac (pacemaker, etc.)
- □ Joint Implants/replacements
  specify ___________________
  ____
- □ Other implants or supports *including heal or sole lifts*
  specify ___________________
  ____

Other
Is there anything else you feel we should know about you?
____
____
____
____

Condition_____________Physician___________________Address_________________________Phone________
Condition_____________Physician___________________Address_________________________Phone________
Condition_____________Physician___________________Address_________________________Phone________