"Back In Balance"

Elana Kaplove DC PA
7035 Beracasa way Suite # 104
Boca Raton, Fl 33433
Office # 561-361-4888 / Fax # 561-361-4999

Confidential Patient Background

Date: ___/___/________

Please PRINT clearly & answer COMPLETELY ("N/A" if not applicable)!

1) Name ____ 2) ☐ Male ☐ Female

Nickname________________________ 3) **Date of birth: ____/ ____/____**

4) Address ____________________________City_____________________Zip____________

5) Home Phone (_____) __________________ 6) E-mail ____________________________

7) Work Phone (_____) ___________________ 8) Cell Phone (_____) __________________

9) Preferred Contact Method (Circle One): E-mail Phone Calls Text Message

10) Social Security # ______-_____-_______ 11) Occupation ________________________

12) Employer ______________________________Address ____________________________

13) ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed 14) Race/Ethnicity ____________

Special Circumstances ____

15) Emergency contact _______________________________________Phone ___________________

16) Religious preference (optional) ____________17) Payment method/insurance _____________

18) How were you referred to us, or by whom? __________________________________

We strive to be more connected to our patients and in order to offer the highest level of wellness. We will never sell or share your information without your permission, ever.

19) Will you permit us to text you with weekly/monthly specials? ☐ **Yes** ☐ **No**

20) Do you give us permission to send you our monthly newsletter? ☐ **Yes** ☐ **No**

21) Do you have a Facebook Account? ☐ **Yes** ☐ **No**

22) Do you permit us to email you? ☐ **Yes** ☐ **No**

Present Condition:

1) What issues brought you here today? ____

____

2) If pain is involved, what is the severity on a scale of 0-10 (0 being no pain)? ____________

3) If you are experiencing pain or discomfort, what was the date of onset? _____/_____/_____

4) Quality (Please describe) ____

5) Palliative (What makes it better or worse?) ____

6) Radiating or referring (Does pain move?) ____

7) Site (Point to it) ____

8) Timing (Constant or only with certain activities?) ____

9) On a scale of 1 to 10 (with 10 being the highest), what is your current stress level? _________

Health History

1) Previous/current CHIROPRACTIC care? □ Yes □ no If so, by whom, when, & for what?
____

2) Other alternative treatments? ____

3) Recent films or diagnostics (e.g. X-ray, mammogram, MRI, PET, CAT, DEXA, labs)? □ yes □ no

What/how recent? ____

4) Currently under other care? □ Yes □ no If so, where, since when, by whom?

____

5) Surgeries & dates____

____

6) Accidents/Traumas ____

7) Infections (incl. HIV) _________________________8) Immunizations ________________

9) Allergies ____

10) **All other conditions** (physical, mental and/or emotional) ___________________________

____

11) Do you currently take **any** over-the-counter (OTC) medication? □ yes □ no
If YES, what, and how often? ____

12) Are you currently taking any prescriptions, (including birth control)? □ Yes □ no If so, WHAT?

____

13) Have you had recent significant weight changes? □ Yes □ no If so, explain ______________

____

Social History:

1) Sexual Orientation _______________________ 2) Are you sexually active? □ yes □ no

3) # of Work Hours/Day? ____________________ 4) # of Sleep Hours/Night? _______________

5) Do you smoke? (Now or EVER) □ yes □ never □ in the past If so, How Many Packs/Day?____

6) Do you consume **any** alcohol? (Now or in the past) □ yes □ no # Drinks/Week ____________

Family Information

1) # of Children ___________ 2) Step Children ___________ 3) Grand Children? __________

Names and Ages ____

2) For WOMEN: Age @ 1st Period _______ # Pregnancies _______ Age @ Menopause _________

Family History:

*** Any history of diabetes, HBP, cancer, CVA, or arthritis in your family? □ yes □ no**

1) **Mother**—Still living? □ yes □ no If no, age and cause of death: ___________________________

Mother's Health history ____

2) **Father**—Still living? □ yes □ no If no, age and cause of death: ___________________________

Father's Health history ____

3) **Grandparents'** health history

MGM ___________________________ **PGM** ___________________________________

MGF ___________________________ **PGF** ____________________________________

4) **Siblings'** health history ____

Dietary/Digestive Fitness:

1) Does your diet include coffee/tea, fast food, and/or soda/pop or diet drinks? □ yes □ no

2) Does your daily diet include fruits/vegetables? □ yes □ no If yes, how many servings? ______

3) Do you eat red meat? □ Yes □ no if yes, How much? ___________________________________

4) How much water do you consume daily? ____

6) How many times do you urinate daily (average)? _________ Any unusual symptoms? _____

7) How many bowel movements do you have daily? ___________ Any unusual symptoms? ______

8) Taking any dietary supplements including vitamins/minerals, fiber and/or herbs? □ yes □ no

If yes, what KIND, DOSAGE & FREQUENCY: ____

____

Occupational History:

1) Job history____

2) Is this job-related? □ Yes □ no If yes, describe: ____

3) Are you experiencing any work restrictions as a result of your present condition? □ yes □ no

4) If yes, describe:____

Ergonomics:

1) How comfortable is your mattress? _______________________Pillow?_______________________

2) What position do you sleep in (back, side, stomach)? ____________________________________

3) Have you difficulty falling asleep? □ yes □ no 4) Do you sleep through the night? □ yes □ no

5) How many hours per day are you at a computer (on average)? ___________________________

Position of monitor/keyboard/chair/telephone ______________________________________

6) How do you get to work? __________________ How long does it take? ___________

7) Do you have difficulty sitting for long periods? □ In the past □ Currently □ Never

8) Do you have difficulty standing for long periods? □ In the past □ Currently □ Never

9) Do you have difficulty walking for long periods? □ In the past □ Currently □ Never

10) What form of exercise do you do? Frequency:_______per _______ Type: _________________

____

11) Primary position while working (sitting/ standing/ walking)? _____________________________

12) What kind of shoes do you wear? ____

13) Do you wear inserts/arch supports in your shoes? □ yes □ no