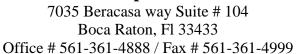


# "Back In Balance"

## Elana Kaplove DC PA





# **Confidential Patient Background**

		Date: _	//		
Please PRINT clearly & answer	· COMPLETELY ("N	I/A" if no	nt applica	able)!	
1) Name			_ 2) □ Male	e □ Female	
Nickname	3) <b>Date</b>	of birth: _	/	/	
4) Address	<u>City</u>		Zip		
5) Home Phone ()	6) E-mail				
7) Work Phone ()	8) Cell Phone (	)			
9) Social Security #	10) Occupation				
11) Employer	Address				
12) □ Single □ Partnered □ Married □ Div	orced 🗆 Widowed 13	3) Race/Eth	nicity		
Special Circumstances					
14) Emergency contact					
15) Religious preference (optional)16) Payment method/insurance					
17) How were you referred to us, or by wh	om?				
Dresent Condition:					
Present Condition:					
1) What issues brought you here today?					
2) If pain is involved, what is the severity of	on a scale of 0-10 (0 b	eing no pa	in)?		
3) If you are experiencing pain or discomfo	ort, what was the date	of onset? _	/	/	
4) Quality (Please describe)					
5) Palliative (What makes it better or worse	e?)				
6) Radiating or referring (Does pain move?					
7) Site (Point to it)					
8) Timing (Constant or only with certain ac					
9) On a scale of 1 to 10 (with 10 being the	highest), what is your	current st	ress level?	·	

## **Health History**

1)	Previous/current CHIROPRACTIC care?   Yes   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)? $\Box$ yes $\Box$ no				
	What/how recent?				
4)	Currently under other care? $\Box$ Yes $\Box$ 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 <b>any</b> over-the-counter (OTC) medication? □ yes □ no     If YES, what, and how often?				
12	?) Are you currently taking any prescriptions, (including birth control)? $\square$ Yes $\square$ no If so, WHAT?				
13	B) Have you had recent significant weight changes?   Yes   no If so, explain				
<u>S</u>	ocial 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) $\square$ yes $\square$ never $\square$ in the past $\square$ If so, How Many Packs/Day?				
6)	Do you consume <b>any</b> 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 <u>WOMEN</u> : Age @ 1 <sup>st</sup> Period # Pregnancies Age @ Menopause				
Family History:				
* Any history of diabetes, HBP, cancer, CVA, or arthritis in your family? $\ \square$ yes $\ \square$ no				
1) <b>Mother</b> —Still living? □ yes □ no If no, age and cause of death:				
Mother's Health history				
2) <b>Father</b> —Still living? □ yes □ no If no, age and cause of death:				
Father's Health history				
3) <b>Grandparents'</b> health history				
MGM PGM				
MGF PGF				
4) Siblings' health history				
<u>Dietary/Digestive Fitness</u> :				
1) Does your diet include coffee/tea, fast food, and/or soda/pop or diet drinks? $\square$ yes $\square$ no				
2) Does your daily diet include fruits/vegetables? $\square$ yes $\square$ no If yes, how many servings?				
3) Do you eat red meat? □ Yes □ no if yes, How much?				
3) Do you eat red meat?   Yes   no if yes, How much?  4) How much water do you consume daily?				
4) How much water do you consume daily?				
4) How much water do you consume daily? Any unusual symptoms? Any unusual symptoms?				
<ul> <li>4) How much water do you consume daily? Any unusual symptoms?</li> <li>6) How many times do you urinate <u>daily</u> (average)? Any unusual symptoms?</li> <li>7) How many bowel movements do you have <u>daily</u>? Any unusual symptoms?</li> </ul>				

# **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? $\square$ yes $\square$ no 4) Do you sleep through the night? $\square$ yes $\square$ 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? $\Box$ In the past $\Box$ Currently $\Box$ Never
8) Do you have difficulty standing for long periods? $\Box$ In the past $\Box$ Currently $\Box$ Never
9) Do you have difficulty walking for long periods? $\Box$ In the past $\Box$ Currently $\Box$ 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