"Back In Balance"

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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) Social Security # _____-_____-_____ 10) Occupation _____

11) Employer _____Address_____

12) □ Single □ Partnered □ Married □ Divorced □ Widowed 13) Race/Ethnicity _____

Special Circumstances _____

14) Emergency contact _____Phone_____

15) Religious preference (optional) _____16) Payment method/insurance _____

17) How were you referred to us, or by whom? _____

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