BalanceChiropractic

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Mesa, AZ 85207 480.830.0175

Chiropractic Intake Form

Name_____ **Date**_____
Address_____ **City**_____ **State**_____
Date of Birth_____**Age**_____ **Phone**_____
Email Address_____ **Employer** _____
Emergency Contact_____ **Phone**_____
Referred By _____

☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Smoking Status (circle one): Every day/ Occasionally/ Former/ Never
Smoking Start Date (Optional):_____ **How Many Packs per Day:**_____

Gender: Male Female

Race (circle one): American Indian or Alaskan Native/ Asian/ Black or African American/ White(Caucasian)/ Native Hawaiian or Pacific Islander/ Decline to Answer

Ethnicity (circle one): Hispanic or Latino/ Not Hispanic or Latino/ Decline to Answer

How will you be taking care of your bill?

☐ **Self Pay** ☐ **Medical Insurance** ☐ **Medicare** ☐ **Other** _____

Research is showing that much of the sickness that occurs later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years	Yes	No	Unsure	Comments (if any)
Did you have any childhood illnesses?	☐	☐	☐	_____
Were you vaccinated?	☐	☐	☐	_____
Did you have any falls from a height over 3 feet? (i.e. crib, bunk bed, trees)	☐	☐	☐	_____
Did you play youth sports?	☐	☐	☐	_____
Did you take/use any drugs?	☐	☐	☐	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐	_____
Were you involved in any car accidents?	☐	☐	☐	_____
Did you suffer any form of abuse?	☐	☐	☐	_____
Were you under regular chiropractic care?	☐	☐	☐	_____

FOR OFFICE USE :
Patient Weigh:_____ Height:_____ Blood Pressure_____/_____

Each of us must balance a variety of demands on our time, money and emotions. Please rate the following items, in order, relative to their importance to you with a (1) being the most important and (7) being the least important.

____ Marriage ____ Automobile ____ Job ____ Health
____ House ____ Kids ____ Pet

On a scale of 1-10 describe your level of stress (1 = none / 10 = extreme)
Occupational _____ Personal _____

At our office, we are not only interested in how you feel and your well-being, but also the well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:
Children_____
Spouse _____
Mother/Father_____
Siblings _____
Others _____

Social History	**Yes**	**No**	
ALCOHOL	☐	☐	If Yes, how much _____
POOR SLEEP HABITS	☐	☐	How many hours per night _____
EXTREME SPORTS	☐	☐	If Yes, explain _____

Are you currently taking any medication? _____Yes _____No
If Yes, please list:
_____
_____

Do you have any drug allergies? _____Yes _____No
If Yes, please list:
_____
_____

Family History
Did you mother or father have any of the following: **M** is for mother, **F** is for father.

M	F		M	F	
☐	☐	High Blood Pressure	☐	☐	Ulcer or Stomach Problems
☐	☐	Heart Attack	☐	☐	Stroke (Age at occurrence M ____ F_____)
☐	☐	Emphysema	☐	☐	Cancer
☐	☐	Seizure-Convulsions	☐	☐	Arthritis-Rheumatism
☐	☐	HIV Positive	☐	☐	Mental Illness
☐	☐	Asthma	☐	☐	Thyroid Disease
☐	☐	Diabetes	☐	☐	Circulation Problems
☐	☐	Kidney Disease			

FOR OFFICE USE:
Patient Name: _____ Date of Birth: _____ Doctor Initials: _____

Addressing the Issues that Brought you to the Office

Briefly describe your main concern.

_____

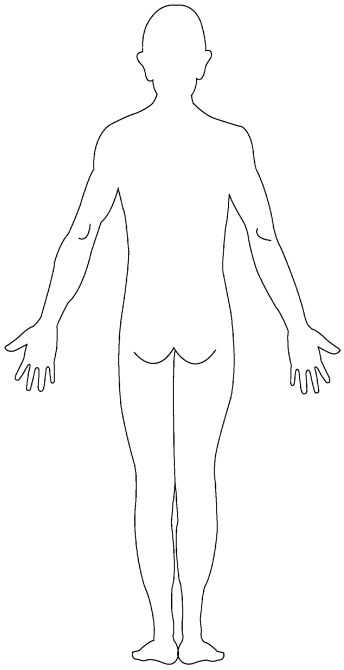
_____

1) If you are experiencing a symptom, is it… (check more than one if necessary)

☐ Sharp ☐ Dull ☐ Burning ☐ Numbness & Tingling

☐ Pressure ☐ Comes and Goes ☐ Travels ☐ Constant

2) Where is the symptom? (Indicate on drawing) _____



3) Please indicate your pain levels right now:

No Pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4) When did the symptom first start? _____

_____

5) Since the symptom started, it is…

☐ About the same ☐ Getting Better ☐ Getting Worse

6) What makes it worse: _____

7) What makes it better: _____

7) Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Travel

8) Does this cause you to be: ☐ Irritable ☐ Moody ☐ Worried

9) Is your Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury

10) Other Doctors seen for this problem and when (please list).

☐ Chiropractor _____

☐ Medical Doctor _____

11) Drugs you now take: ☐ None

☐ Over-The-Counter Pain Relievers ☐ Prescription Pain Medications ☐ Muscle Relaxant

☐ Blood Pressure Medicine ☐ Insulin ☐ Other _____

12) Past Surgeries/ Operations (please list)

_____

_____

13) Falls/ Accidents/ Major Trauma (please include date and circumstances)

_____

_____

FOR OFFICE USE:

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Personal History Survey

	Yes	No	Explain Symptoms
Do you have vertigo (dizziness)?	☐	☐	_____
Do you pass out easily (faint or loss of consciousness)?	☐	☐	_____
Do you have double vision or have you lost sight in one eye?	☐	☐	_____
Do you have any slurred speech or difficulty with speech?	☐	☐	_____
Do you have indigestion or difficulty swallowing?	☐	☐	_____
Do you have any difficulty walking, with coordination or falling to one side?	☐	☐	_____
Do you have nausea or vomiting?	☐	☐	_____
Do you have or have you ever had difficulty in arranging words properly?	☐	☐	_____
Do you have a headache or head pain that is unlike any you have had before?	☐	☐	_____
Do you have chest pain?	☐	☐	_____
Do you have any change in bowel or bladder habits?	☐	☐	_____
Do you have a sore that does not heal?	☐	☐	_____
Do you have a change in any wart or mole?	☐	☐	_____
Do you have a nagging cough or hoarseness?	☐	☐	_____
Do you have night sweats?	☐	☐	_____
Do you have any ringing in your ears?	☐	☐	_____
Do you take birth control pills?	☐	☐	_____
Have you gained or lost a significant amount of weight in last year?	☐	☐	_____
Do you have asthma?	☐	☐	_____
Do you have diabetes?	☐	☐	_____
Do you have a history of high blood pressure?	☐	☐	_____
Have you been diagnosed with any heart conditions?	☐	☐	_____
Have you been diagnosed with osteoporosis?	☐	☐	_____
Have you had a history of dental problems	☐	☐	_____
Do you have TMJ (temporal-mandibular joint) problems?	☐	☐	_____

There are five ways our patients use chiropractic care:

Relief Care for the most obvious symptoms
Corrective Care for their underlying problem
Maintenance Care to sustain their progress
Preventive Care to catch new problems early
Wellness Care to be all that they can be

Be thinking of how far you want to take your care when you meet the doctor.

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INFORMED CONSENT/FINANCIAL POLICY

When a patient seeks chiropractic and/or massage health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be use to attain it. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic and/or massage care after being advised of the known benefits, risks and alternatives.

Terms and Definitions:
Massage: The rubbing, or kneading, of muscles and joints of the body to relieve pain and stress.
Health: State of optimal physical, mental and social well being, not merely the absence of disease/infirmity.
Adjustment: Specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Vertebral Subluxation: Misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Regarding Chiropractic Care: We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxation, and massage treatments. However, we may use other procedures to help your body hold the adjustments. POSSIBLE RISKS AND COMPLICATIONS ASSOCIATED WITH THE PROCEDURES INCLUDE SORENESS, DIZZINESS, FRACTURE/JOINT INJURY AND STROKE. ALTERNATIVE TREATMENTS INCLUDE MEDICATIONS, REST/EXERCISE, SURGERY AND NON-TREATMENT.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Balance Chiropractic will bill my insurance, as a courtesy, but cannot guarantee that my carrier will pay my claim. I understand that if my claim is denied by my carrier, the obligation for payment is mine. Balance Chiropractic will supply patients with statements, reports, or other documents to help them receive reimbursement from third party. I hereby authorize the doctor to treat my condition as he/she deems appropriate through the use of, but not limited to, spinal adjustments. My X-rays will remain property of this office and will be on file where I may see them at any time while I am a client of this office.

I therefore have read, fully understand and questions have been answered regarding the above and accept chiropractic care on this basis.

_____ _____
(signature) (date)

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child: I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic and/or massage care.

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Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	

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