

BACK INTO BALANCE – New Patient Intake Form (Page 1 of 3)

HOW CAN WE SERVE YOU?

Subluxations (spinal misalignments) cause most of the unwanted health conditions people suffer from every day.
 Have you had an auto accident? Yes No If yes, number of accidents and year(s) _____
 I have no complaints. I am here for a wellness check up. Date of Birth: _____
 Have you had Chiropractic care before? No Yes Year? _____ Where? _____
Have you had Spinal Surgery? Yes No **When?** _____ **Was METAL inserted?** Yes No **Where?** _____

YOUR HEALTH CONCERNS:

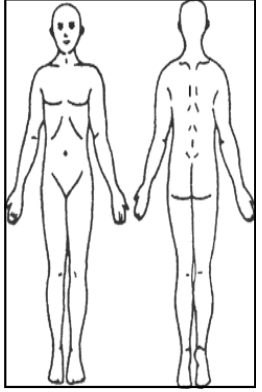
1) What is your **FIRST** health concern? _____
 2) When did you first notice this health concern? _____
 3) Does this problem stay in one area OR radiates/travels to my _____
 4) Is this pain: Sharp Dull Burning Throbbing Aching Numbness
 5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? Yes No
 6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
 7) Is you condition: Episodic Frequent All the time
 8) What treatments have you already tried to help with this condition? _____

 9) For this problem have they performed: MRI CT X-Ray Surgery Other _____
 10) How has this health concern affected your activities and your life? _____

 11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years

 12) Notes: _____

Mark the area of your
FIRST concern.



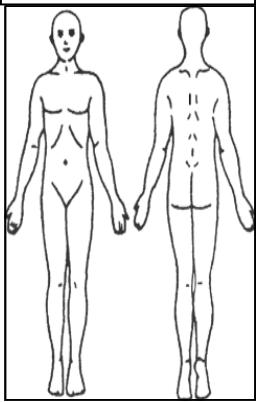
1) What is your **SECOND** health concern? _____
 2) When did you first notice this health concern? _____
 3) Does this problem stay in one area OR radiates/travels to my _____
 4) Is this pain: Sharp Dull Burning Throbbing Aching Numbness
 5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? Yes No
 6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
 7) Is you condition: Episodic Frequent All the time
 8) What treatments have you already tried to help with this condition? _____

 9) For this problem have they performed: MRI CT X-Ray Surgery Other _____
 10) How has this health concern affected your activities and your life? _____

 11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years

 12) Notes: _____

Mark the area of your
SECOND concern.

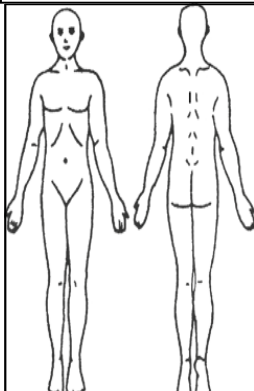


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	Pre	Post	KVP: 76 MA:120	Lat: T: _____	Nas: S: _____ T: _____	E: _____ Rot: _____	Vertex: T: _____ Neck: _____
Leg Check			Degeneration Phase: _____	Total # Time: _____	Schedule: _____	Source: _____	Spouse: _____
Anatometer							
Shoulder			Therapy Code: _____	ID#	DOB:	Date:	
Hip							
Thermography							
Name: _____							

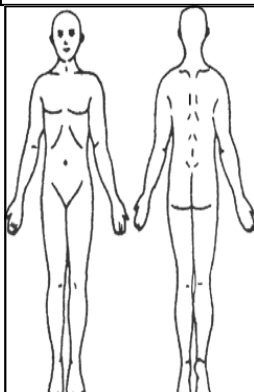
- 1) What is your **THIRD** health concern? _____
- 2) When did you first notice this health concern? _____
- 3) Does this problem stay in one area OR radiates/travels to my _____
- 4) Is this pain: Sharp Dull Burning Throbbing Aching Numbness
- 5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? Yes No
- 6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
- 7) Is you condition: Episodic Frequent All the time
- 8) What treatments have you already tried to help with this condition? _____
- 9) For this problem have they performed: MRI CT X-Ray Surgery Other _____
- 10) How has this health concern affected your activities and your life? _____
- 11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years _____
- 12) Notes: _____

Mark the area of your **THIRD** concern.



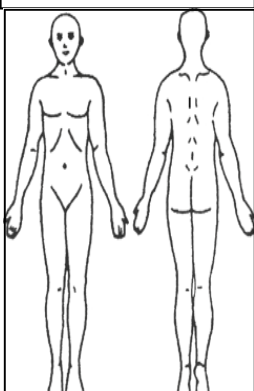
- 1) What is your **FOURTH** health concern? _____
- 2) When did you first notice this health concern? _____
- 3) Does this problem stay in one area OR radiates/travels to my _____
- 4) Is this pain: Sharp Dull Burning Throbbing Aching Numbness
- 5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? Yes No
- 6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
- 7) Is you condition: Episodic Frequent All the time
- 8) What treatments have you already tried to help with this condition? _____
- 9) For this problem have they performed: MRI CT X-Ray Surgery Other _____
- 10) How has this health concern affected your activities and your life? _____
- 11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years _____
- 12) Notes: _____

Mark the area of your **FOURTH** concern.



- 1) What is your **FIFTH** health concern? _____
- 2) When did you first notice this health concern? _____
- 3) Does this problem stay in one area OR radiates/travels to my _____
- 4) Is this pain: Sharp Dull Burning Throbbing Aching Numbness
- 5) On a scale of 0 to 10. 0= No Pain 10=Worst Pain Possible. Is it ever at a 0? Yes No
- 6) Please **circle the range** of pain 0 1 2 3 4 5 6 7 8 9 10
- 7) Is you condition: Episodic Frequent All the time
- 8) What treatments have you already tried to help with this condition? _____
- 9) For this problem have they performed: MRI CT X-Ray Surgery Other _____
- 10) How has this health concern affected your activities and your life? _____
- 11) If left unchanged, how do you see this health concern affecting your life 1 year from now? 15 years _____
- 12) Notes: _____

Mark the area of your **FIFTH** concern.



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Name: _____

ID# _____

Please indicate any MAJOR health concerns you are experiencing

NEUROLOGICAL CODE

- Headaches, Numbness/Tingling, Loss of Balance, Paralysis, Dizziness, Depression, Fainting

GENERAL CODE

- Fatigue/Low Energy, Allergies/Hay Fever, Loss of Sleep/Trouble Sleeping

EENT CODE

- Vision Problems, Dental Problem, Sore Throat, Earache, Hearing Difficulty, Sinus Trouble, Loss Of Smell, Loss Of Taste, Ringing In Ears

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite, Frequent Nausea/Vomiting, Diarrhea, Constipation, Hemorrhoids, Abdominal Cramps, Gas/Bloating After Meals, Ulcers

GENITO-URINARY CODE

- Bladder Trouble, Painful/Excessive Urination, Kidney Trouble

CARDIOVASCULAR CODE

- Chest Pain, Shortness of Breath, High Blood Pressure, High Cholesterol, Irregular Heartbeat, Lung Problems/Congestion, Ankle Swelling, Stroke, Asthma

FEMALES ONLY

- Menstrual Irregularity, Menstrual Cramps, Vaginal Pain/Infection, Breast Pain/Lumps

To determine if x-rays can be safely performed, when was your last period? _____

Are you pregnant? Yes No, Menopausal? Yes No

MALES ONLY

- Prostate Problems, Erectile/Sexual Dysfunction (ED)

OTHER HEALTH CONCERNS NOT LISTED

FAMILY HISTORY

The following members of my family have the same or similar problems:

- Mother, Father, Brother, Sister, Spouse, Child

INSURANCE INFORMATION

Insurance Company, Medicare Yes No, Is Medicare: Primary, There is a supplemental, I transferred my Medicare to another insurance company.

OTHER INFORMATION

Height: Weight: Emergency Contact: Phone Number:

CONSENT TO EXAMINATION, PLEASE READ AND SIGN BELOW

I hereby authorize the Doctor to examine my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays is for the information only and the X-ray negatives will remain the property of this office...

Patient's Name (Print): Patient's Signature: Date: Guardian or Spouse's Signature to treat Minor: Date:

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Name: ID#