



BODY IN BALANCE CHIROPRACTIC, P.C

755 Heritage Road, #110, Golden, CO, 80401. 303-215-0390. www.bodyinbalancechiropractic.com

Welcome to Body in Balance Chiropractic! We are excited you are here. Our office offers a unique service to individuals and families. We want to serve you to the best of our ability. Please be as thorough as possible when completing this form.

Name: _____ Sex: Male / Female Today's Date: _____
 Address: _____ Employer: _____
 City: _____ State: _____ Zip: _____ Occupation: _____
 Home Phone: _____ Social Security #: _____
 Work Phone: _____ Marital Status: S / M / D / W
 Cell Phone: _____ Name of Spouse: _____
 Age: _____ Date of Birth: ____/____/____ Names and Ages of Children: _____
 E-mail: _____

Emergency Contact information: _____ Ph # _____
 Who told you about Body in Balance Chiropractic? _____

There are many misconceptions about the human body and chiropractic. Are you aware that...
 ...the nervous system controls everything in the body, including healing? Y / N
 ...the spinal cord is part of the brain that travels through the spine? Y / N
 ...the brain communicates with the organs of the body through the nerves? Y / N
 ...when bones of the spine are out of alignment, pressure is placed on the spinal cord and nerves? Y / N
 ...chiropractic is the largest natural healing profession in the United States? Y / N
 ...research states that for optimal health your spine should be maintained from birth? Y / N

Part I

CURRENT HEALTH CONCERNS

Why are you specifically seeking care at this office? _____

When did this condition or symptom begin? _____ (Please explain the event or process in which you feel this started.)

How often do you experience your health concern? _____

What describes your health concern? (circle all that apply)
Sharp / Dull / Achy / Shooting / Burning / Numbness / Tingling / Other: _____

Are your symptoms? Getting better / Staying the same / Getting worse

What have you done about this concern? _____

If this condition/symptom were to go away tomorrow, what would be different about your life?

Part II

Continued on next page...

HEALTH, WELLNESS, AND NETWORK CARE

The human body is designed to function properly. Throughout life, stresses and traumatic events can harm the body and alter your life expression. Our objective in this office is to help your body not only function properly, but also develop new strategies for living with vibrant health and wellness. In our analysis, we want to identify any potential stress to which your body cannot adapt. These stresses may be **Physical, Chemical, or Emotional** in nature. We are assisted in serving you by understanding the stresses that have acted upon your spine and nervous system. Please be as specific and thorough as possible when completing the following information regarding the past and current stresses and traumas of your life. Each question is important for us and will provide us with the information needed to deliver exceptional care to you.

HEALTH HISTORY

Have you ever had your spine and/or nervous system professionally evaluated by a chiropractor? Y / N

Have you ever been adjusted by a chiropractor? Y / N - Date of your last adjustment? ___/___/___

If yes, how often did you go? What techniques did he or she use?

Do you have a family medical doctor? Y / N

Do you consult with him or her regularly? Y / N If yes, why? _____

Has anyone in your family suffered a serious illness? _____

ILLNESS HISTORY

Research has shown that many of the health challenges that occur later in life have their origins during the developmental years, some starting at or before birth. Please answer the following questions to the best of your ability.

Physical, Chemical, & Emotional Stress:

Sports and recreational activities can be injurious to the spine and can also cause many muscle imbalances. Please list any present or past sports or recreational activities you participate/ed in:

Please describe any injuries you are/were aware of:

Date of last automobile accident: ___/___/___ Speed: _____ Injuries: _____

Date of automobile accident before that: ___/___/___ Speed: _____ Injuries: _____

Please list and date any additional known physical injuries or accidents:

Name: _____ Date: _____

Continued on next page...

Have you ever been knocked unconscious? Yes / No
Have you ever had any broken bones? Yes / No
Have you ever been hospitalized or had surgery? Yes / No
If yes for any of the above three, please explain:

For females: Are you currently pregnant? _____

Are you currently taking any drugs (prescription or over-the-counter)?
Please list each drug with the specific reason that you are taking it:

In the past, have you taken any medication regularly (for example, long-term use of antibiotics or an inhaler)?
Please list each drug with the specific reason that you took it:

Are you currently taking any supplements?
Please list each supplement with the specific reason that you are taking it:

Do you have any know food allergies or sensitivities? _____

Stress is a severe problem in the majority of peoples' lives today.
On a scale of 1 (mild) -10 (severe) rate your stress on a typical day. _____

Have you experienced any of the following in the past 12 months?

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent colds, flu | <input type="checkbox"/> Shoulder pain (L/R) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing in ears (L/R) |
| <input type="checkbox"/> Allergy, sinus problems | <input type="checkbox"/> Irritableness | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blurred or double vision |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High stress | <input type="checkbox"/> Upper back pain/stiffness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Lower back pain/stiffness |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Hip pain (L/R) |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Gall Bladder problems | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Menstrual problems, PMS | <input type="checkbox"/> High/low blood pressure |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Neck pain or stiffness (L/R) | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Numbness, tingling, pain in arms, hands, or fingers (L/R) | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Cancer | | |

Please indicate your:

Blood Pressure: ____/____ Height: _____ Weight: _____

Is there anything else not covered on this form that you feel is relevant for the Dr. to know about you?

Name: _____ Date: _____