total balance
CHIROPRACTIC

Name: _____ Date:_____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ DOB: _____ Age: _____ ◯ Male ◯ Female Height: _____ Weight: _____

Home #: _____ Work #: _____ Cell #: _____

Best time to contact: _____ How did you hear about us? _____

Email address: _____ Status: ◉ Single ◯ Married ◯ Divorced ◯ Widowed

Number of Children: _____ Names/Ages: _____

Occupation: _____ Employer Name/Phone: _____

Your Health Profile

What brings you into our office today? Please briefly describe any health symptoms, including the impact it has had on your life. Please rate the severity (scale 1-10, 1 being mild). Also include when and how did this start? Are symptoms constant or intermittent?

_____

_____

_____

_____

Since the problem started it is: ◯ the same ◯ getting better ◯ getting worse

What makes the problem worse? _____

_____

What, if anything makes the problem better? _____

_____

Does this interfere with your: ☐ Leisure ☐ Work ☐ Sleep ☐ Sports ☐ Other_____

_____

Have you seen other doctors for this condition? ☐ Chiropractor ☐ MD

Other Name/Address: _____ Date: _____

What was the diagnosis: _____

General Health

Please list all medications and supplements you are taking, and why. (Prescription and non-prescription) _____

_____

_____

_____

Have you had any surgeries and/or hospitalizations? ◯ Yes ◯ No

If yes, briefly explain: _____

_____

_____

Have you ever had any work related injuries? ◯ Yes ◯ No

If yes, briefly explain: _____

_____

Have you ever had any slips, falls or auto accidents? ◯ Yes ◯ No

If yes, briefly explain: _____

_____

Do you have a history of sexual abuse? ◯ Yes ◯ No

If yes, have you sought professional counseling? ◯ Yes ◯ No

Please check all symptoms you have currently (C) or have had in the past (P), even if they do not seem related to your current problem. You may write notes to explain, if desired.

(C)	(P)		(C)	(P)	
☐	☐	Headaches	☐	☐	Fever
☐	☐	Pins & needles in arms	☐	☐	Dizziness
☐	☐	Pins & needles in legs	☐	☐	Numbness in fingers
☐	☐	Sleeping problems	☐	☐	Fatigue
☐	☐	Tension	☐	☐	Urinary problem
☐	☐	Acid reflux or ulcers	☐	☐	Fainting
☐	☐	Buzzing in ears	☐	☐	Eyes bothered by light
☐	☐	Ringing in ears	☐	☐	Stomach problems
☐	☐	Numbness in toes	☐	☐	Diarrhea
☐	☐	Depression	☐	☐	Cold sweats
☐	☐	Constipation	☐	☐	Mood Swings
☐	☐	Menstrual pain	☐	☐	Loss of smell
☐	☐	Menstrual irregularity	☐	☐	Loss of taste
☐	☐	Hot flashes	☐	☐	Back pain
☐	☐	Irritability	☐	☐	Neck Pain
☐	☐	Cold hands	☐	☐	Stiff neck
☐	☐	Cold feet	☐	☐	Digestive problems:

Current Lifestyle

On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale =____ Occupational stress: _____

Scale =____ Personal stress: _____

Please indicate what you consume in a typical day:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Beverages: _____

Habits (please check all that apply):

- ☐ Alcohol
- ☐ Tea
- ☐ Cigarettes
- ☐ Laxatives
- ☐ Sugar
- ☐ Coffee
- ☐ Chocolate
- ☐ Sugar Substitute

Do you consider yourself: ◯ Overweight ◯ Average ◯ Underweight

Describe activity level: ◯ Sedentary ◯ Light ◯ Moderate ◯ Heavy

How many meals do you typically eat out in a week? _____ How many glasses of water do you drink daily? _____

List any foods you crave: _____

List any foods you avoid (for any reason): _____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals in the following categories:

Be Fit. (Physical)	Eat Right. (Nutritional)	Think Well. (Psychological)

Provider

Please indicate if would like to see a specific doctor. If you have no preference you may leave this blank.

◯ Dr. Sarah Weber ◯ Dr. Andrea Shavitz

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

If you filled this form out at home, you may print it and bring it with you to your first appointment or email it to us at office@totalbalancechiro.com. Otherwise please return this form to the front desk and someone will be right with you.