

WELCOME TO COMPLETE BALANCE

Practice Member Name: _____ Date: _____ Age: _____ Birth date: _____

Address: _____

Home Telephone (_____) _____ Residence _____ City _____ State _____ Zip Code _____
Cell Phone (_____) _____ Male _____ Female _____

Social Security # _____ Driver's Lic. # _____ E-Mail _____

Occupation _____ Employer _____ Work Phone (_____) _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____

No. of children: _____ Emergency Contact _____ Phone (_____) _____

Can Dr. communicate with you through email? Yes No Would you like to receive our monthly newsletter? Yes No

Who may we thank for referring you to our office?

Your Health Information

What are your objectives in consulting our office? _____

What other wellness professionals are currently a part of your health care team?

Massage Therapist Acupuncturist Naturopath Homeopath Other _____

How many Medical Doctor's office visits did you and your family have last year?

None Less than 5 More than 5 More than 10

Have you had previous Chiropractic care? Yes No This year? Yes No

List previous surgeries and dates: _____

Medications: Pain Meds Birth Control Heart Meds Cholesterol Meds Other _____

Has a Doctor ever put you on a Wellness Program to improve your health? Yes No

If yes, did you follow the doctor's recommendations? Yes No

If no, would you be interested in a Wellness Program (Improving your Nutrition, Exercise and Stress Management) Yes No

Health History

Please check () all of the following health concerns that you have experienced in the last five years, even if you think that your answers do not relate to your present health concern.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pins & Needles in Legs |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Headache | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn/Acid Reflux | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Circulatory/Vascular Problems | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Urinary Difficulty |
| <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Immune System Disorder | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pins & Needles in Arms | |

Lifestyle History

Please answer the following questions in regard to the 4 main pillars of health. Creating balance in these areas is critical to feeling great, improving your health, and preventing unwanted health issues.

Fitness Balance

Are you happy with your current exercise routine/program? Yes No

What do you like to do for exercise? _____

How often do you exercise? Almost Never Less Than Once a Week Once a Week More Than Once a Week Almost every Day

Are you ready to improve your exercise routine? Yes No

Nutrition Balance

Are you happy with your nutrition program? Yes No

Do you take any nutritional supplements? If Yes, What are you taking? _____

How many glasses of water do you drink in an average day? _____

Are you ready to improve your nutrition? Yes No

Stress Balance

Do you have a daily stress release routine? Yes No

How often do you feel stressed? Never Once a Week More Than Once a Week Almost every Day Always

How would you rate your attitude? Negative 0 1 2 3 4 5 6 7 8 9 10 Positive

Would you like to feel less stress? Yes No

Overall, how would you rate your quality of sleep? Horrible 0 1 2 3 4 5 6 7 8 9 10 Great

Body Balance

How would you rate your posture? Horrible 0 1 2 3 4 5 6 7 8 9 10 Great

Have you ever been involved in a car accident? Yes No

Would you like to improve your posture? Yes No

Your Goals

Which best describes your reason for consulting our office?

- I have a specific concern and require help only with this concern.
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- I want to be healthier five years from now than I am today.

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me (or my minor child-under 18) for further evaluation:

Signature

Print Name

Relationship to Patient if Minor

Date

Sensation Survey

As wellness chiropractors, we are interested in the function of your nervous system. 10% of your nervous system controls our sensations. By answering the following questions, we are able to see how this part of your nervous system is working. It also helps us monitor your progress. Please answer the following questions.

1. How frequently do you get headaches?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 2. On a scale of 1-10 how bad are they when they come?
1 2 3 4 5 6 7 8 9 10
 3. Do they negatively affect your life in any way? If yes, please explain.
-

4. How often do you have pain, stiffness or soreness in your neck?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 5. On a scale of 1-10 how bad is the discomfort?
1 2 3 4 5 6 7 8 9 10
 6. Do you ever get any numbness/tingle/pain in your arms/hands?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 7. Does the discomfort affect your life in any way?
-

8. How often do you have pain, stiffness or soreness in your mid to upper back?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 9. On a scale of 1-10 how bad is the discomfort?
1 2 3 4 5 6 7 8 9 10
 10. Do you ever get any numbness/tingle/pain in your ribs or chest?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 11. Does the discomfort affect your life in any way?
-

12. How often do you have pain, stiffness or soreness in your low back?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 13. On a scale of 1-10 how bad is the discomfort?
1 2 3 4 5 6 7 8 9 10
 14. Do you ever get any numbness/tingle/pain in your legs/feet?
a. Never b. Less than 1x/month c. 1-4x/month d. more than 1x/week
 15. Does this discomfort affect your life in any way?
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Complete Balance Chiropractic

206 S. Placentia Ave. Placentia, CA 92870 Tel (714) 572-9555 Fax (714) 986-9600

Date: _____

Patient: _____

Employer: _____

Claim Group: _____

SS#/ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Complete Balance Chiropractic
206 S. Placentia Ave.
Placentia, CA 92870

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Complete Balance Chiropractic
206 S. Placentia Ave.
Placentia, CA 92870

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at _____ this _____ day of _____, 20_____

Signature of Policyholder/Claimant

Witness