stamford | balance
chiropractic studio

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CONFIDENTIAL HEALTH INFORMATION

Section 1: Personal Information

First Name: _____ Last Name: _____ M.I. _____

Prefers to be called: _____ Birth Date: _____ /_____ / _____

Height: _____ Weight: _____ Age: _____ ☐ Male ☐ Female

Parent or guardian's name if patient is a minor: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

Preferred method of contact: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ E-mail

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Spouse's Name: _____

Number of children: ____ Children's Names and Ages: _____

Are you currently pregnant? ☐ Yes ☐No ☐ N/A

Occupation/Job Description: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) _____

How did you hear about us? _____

Section 2: Your Symptoms

Reason for care: I am here because of a specific issue: ☐ Yes ☐ No *(If No, please go directly to section 3)*

What has prompted you to seek care today? _____

_____

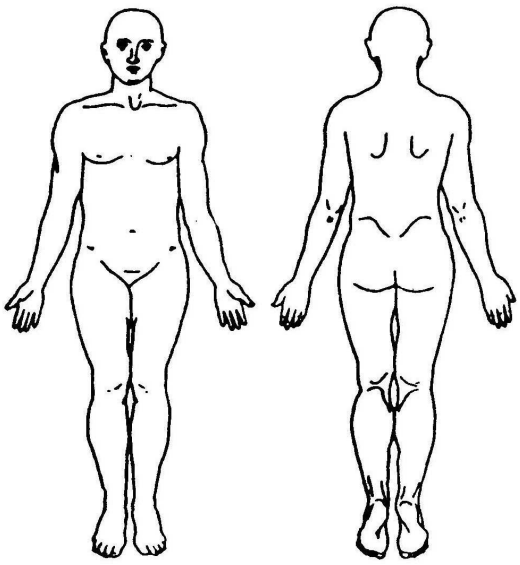
_____

This is the result of: ☐ An accident or injury ☐ A worsening long-term problem ☐ Other _____

When did you first notice your current symptoms? _____

Location:

Please note on this diagram with an "X" where your symptoms are occurring:



Quality of Symptoms:
(What does it feel like?)

- ☐ Dull
- ☐ Achy
- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Sharp
- ☐ Cramping
- ☐ Nagging
- ☐ Sharp
- ☐ Burning
- ☐ Shooting
- ☐ Throbbing
- ☐ Stabbing
- ☐ Other_____

Prior Interventions: (What have you done to try and relieve the symptoms?) _____

_____

_____

How have your symptoms affected your daily activities or routines? _____

_____

Have you missed any work due to your symptoms? ☐ Yes ☐ No

Have you had x-rays taken for this condition? ☐ Yes ☐ No If yes, where? _____

Section 3: Your Personal Health History

Review of systems: (Please mark **all** issues below that you have currently, or have had/been diagnosed with in the past.)
C=Current Issue, P=Past Issue, N=Never has been an issue

A. Musculoskeletal:

Osteoporosis	☐C ☐P ☐N	Foot/Ankle Pain	☐C ☐P ☐N	Neck Pain	☐C ☐P ☐N
Knee Injuries	☐C ☐P ☐N	Scoliosis	☐C ☐P ☐N	Elbow/Wrist Pain	☐C ☐P ☐N
Arthritis	☐C ☐P ☐N	Shoulder Problems	☐C ☐P ☐N	Back Problems	☐C ☐P ☐N
Gout	☐C ☐P ☐N	Hip Disorders	☐C ☐P ☐N	TMJ Issues	☐C ☐P ☐N

B. Neurological

Anxiety	☐C ☐P ☐N	Depression	☐C ☐P ☐N	Headache	☐C ☐P ☐N
Dizziness	☐C ☐P ☐N	Seizures	☐C ☐P ☐N	Numbness	☐C ☐P ☐N
ADD/ADHD	☐C ☐P ☐N	Confusion	☐C ☐P ☐N	Loss of Balance	☐C ☐P ☐N

C. Cardiovascular

High Blood Pressure	☐C ☐P ☐N	High Cholesterol	☐C ☐P ☐N	Angina	☐C ☐P ☐N
Low Blood Pressure	☐C ☐P ☐N	Excessive Bruising	☐C ☐P ☐N	Poor Circulation	☐C ☐P ☐N
Irregular Heart Beat	☐C ☐P ☐N	Pacemaker	☐C ☐P ☐N	Stroke	☐C ☐P ☐N

D. Respiratory

Asthma	☐C ☐P ☐N	Sleep Apnea	☐C ☐P ☐N	Hay Fever	☐C ☐P ☐N
Shortness of Breath	☐C ☐P ☐N	Pneumonia	☐C ☐P ☐N	Emphysema	☐C ☐P ☐N

E. Digestive

Food Sensitivities	☐C ☐P ☐N	IBS	☐C ☐P ☐N	Constipation	☐C ☐P ☐N
Digestion Problems	☐C ☐P ☐N	Ulcer	☐C ☐P ☐N	Diarrhea	☐C ☐P ☐N
Gallbladder Disease	☐C ☐P ☐N	Hemorrhoids	☐C ☐P ☐N	Heartburn	☐C ☐P ☐N

F. Sensory

Blurred Vision	☐C ☐P ☐N	Ringing in Ears	☐C ☐P ☐N	Hearing Loss	☐C ☐P ☐N
Chronic Ear Infection	☐C ☐P ☐N	Loss of Smell	☐C ☐P ☐N	Loss of Taste	☐C ☐P ☐N

G. Skin

Skin Cancer	☐C ☐P ☐N	Eczema	☐C ☐P ☐N	Hair Loss	☐C ☐P ☐N
Psoriasis	☐C ☐P ☐N	Acne	☐C ☐P ☐N	Rash	☐C ☐P ☐N

E. Endocrine

Thyroid Issues	☐C ☐P ☐N	Hot Flashes	☐C ☐P ☐N	Low Energy	☐C ☐P ☐N
Immune Disorder	☐C ☐P ☐N	Frequent Infection	☐C ☐P ☐N	Swollen Glands	☐C ☐P ☐N

F. Urinary

Kidney Stones	☐C ☐P ☐N	Frequent Urination	☐C ☐P ☐N	Bedwetting	☐C ☐P ☐N

G. General

Weight Gain/Loss	☐C ☐P ☐N	Low Libido	☐C ☐P ☐N	Eating Disorder	☐C ☐P ☐N
Appetite Changes	☐C ☐P ☐N	Cancer	☐C ☐P ☐N	Concussion	☐C ☐P ☐N

H. For Females Only:

Difficulty Conceiving	☐C ☐P ☐N	Irregular Periods	☐C ☐P ☐N	Painful Periods	☐C ☐P ☐N
Breast Tenderness	☐C ☐P ☐N	Breast Implants	☐C ☐P ☐N	PMS Issues	☐C ☐P ☐N

I: For Males Only:

Prostate Issues	☐C ☐P ☐N	Impotence	☐C ☐P ☐N	Hernia	☐C ☐P ☐N

Surgeries/Hospitalizations:
Have you had any of the following surgical interventions?
☐ Appendix Removal ☐ Bypass Surgery ☐ Cosmetic Surgery ☐ Elective Surgery _____
☐ Eye Surgery ☐ Hysterectomy ☐ Pacemaker ☐ Spinal Surgery _____
☐ Other _____

Injuries:
Do you have a history of any of the following?
☐ Fractured or broken bone
☐ Spine or nervous system disorder
☐ Being knocked unconscious
☐ Injury in an accident
☐ Other _____

Please list any medications you are taking with reason for use (prescription and over the counter):
_____
_____
_____
_____

Treatments:
Please check the treatments you have received in the past or are receiving currently:

Current	Past	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth Control Pills
☐	☐	Chemotherapy
☐	☐	Dialysis
☐	☐	Herbal Remedies
☐	☐	Homeopathy
☐	☐	Hormone Replacement Therapy
☐	☐	Massage Therapy
☐	☐	Physical Therapy
☐	☐	Other: _____
		_____

Please list any nutritional supplements/vitamins you are currently taking:
_____
_____
_____
_____

Are you currently seeing a primary care medical doctor? ☐ Yes ☐ No

If yes, who is your Medical Doctor? _____
_____

Section 4: Personal Health Habits & Lifestyle

Tell us about your health habits and stress levels.

Alcohol	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Coffee Use	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Energy Products	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Soft Drinks	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Drugs	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Tobacco	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Exercise	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____
Water	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never	How much? _____

Please rate your stress level on a scale from 0-10 (0=no stress and 10=extremely high stress): _____

Section 5: Family History

Please list all important health issues of immediate family members.

Relative	Age (If living)	State of health Good	Poor	Illnesses	Cause of death (If known)
Mother	_____	☐	☐	_____	_____
Father	_____	☐	☐	_____	_____
Sibling	_____	☐	☐	_____	_____
Sibling	_____	☐	☐	_____	_____
Sibling	_____	☐	☐	_____	_____
_____	_____	☐	☐	_____	_____

Section 6: Health Goals

People seek chiropractic care for a variety of reasons. Some people seek symptom relief, others want to correct the cause of the symptoms, and some are seeking to better their health in general. In our office, you and the doctor will discuss your health and current health issues, and choose a plan that is best for your needs. As of right now, let us know what type of care you care you are seeking:

☐ Relief Care: Symptomatic relief of pain or discomfort (a temporary fix to an underlying problem)
☐ Corrective Care: Correcting and relieving the cause of the problem, as well as the symptoms arising from it
☐ Comprehensive Wellness Care: Achieving a high state of health and function within the body
☐ Not sure yet

Section 7: Acknowledgements

To set clear expectation, improve communication and help you get the best results, please read each statement and initial your agreement.

I instruct the chiropractor to deliver the care that, in her professional judgment, can best help me in my restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine, and does not proclaim to cure any named disease or entity. _____ (initial)

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected. _____ (initial)

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. _____ (initial)

I acknowledge that I am responsible for the timely payment of any and all services I receive. _____ (initial)

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern or health issues. _____ (initial)

Signature: _____ Date: _____ /_____ / _____

Signature of parent/guardian if patient is a minor: _____