

Welcome : *To Natural Balance Integrative Health*

Patient Information

Date _____

Patient Name _____

Address _____

City _____ Zip _____

Gender: Male Female

Date of Birth _____ Age _____

Social Security Number _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail Address _____

Single Married Divorced Widowed

of Children _____ Ages _____

Occupation _____

Employer _____

Emergency Contact _____

Relation _____ Phone _____

Have you seen a chiropractor before? Yes No

Have you seen an acupuncturist? Yes No

Have you had a massage before? Yes No

Have you ever had biofeedback? Yes No

How did you hear about Natural Balance?

Insurance Information

I, the undersigned, certify that I, or my dependent, have insurance coverage with _____ and I assign existing benefits to Natural Balance for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Natural Balance to release all information necessary in order to secure payment of benefits. I authorize the use of this signature on all insurance submissions to the company named above.

_____ Date _____

Responsible Party Signature

Subscriber's Name _____

SS# _____ Birth date _____

Accident History

Is your condition due to an accident? Yes No

Type of accident? Auto Work Home Other

To whom have you reported this accident?

Auto Insurance Employer Work Comp Ins.

Primary Complaint

Describe your complaint, including when/how it started:

Physical Activity

None Light

Mod Heavy

Describe:

Work Activity

Sitting Standing

Lt Labor Heavy

Describe:

Habits

Smoke.....Packs/Day _____

Alcohol.....Drinks/Week _____

Coffee.....Cups/Day _____

Exercise.....Days/Week _____

Medications

Name: _____ Dosage and frequency: _____

1. _____

2. _____

3. _____

4. _____

Medical History

Injuries/Illnesses/Conditions _____ Month/Year

Surgeries/Hospitalizations _____ Month/Year

Women Only

Are you currently pregnant? Yes No

Have you ever been pregnant? Yes No

Number of Pregnancies _____

Do you suffer from any of the following?

Menstrual Cramps Hot Flashes

Menstrual Irregularity Menopause

Pre-Menstrual Syndrome Fertility Concerns

Other Symptoms: _____

Patient Name: _____ Date _____

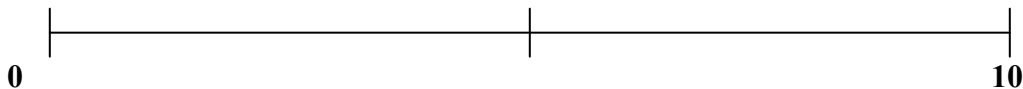
Do you currently have or have you ever been diagnosed with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Numb Arms/Hands |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Numb Legs/Feet |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pain in Upper Limbs |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pain in Lower Limbs |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Irritability | <input type="checkbox"/> Painful Joints |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Skin Dryness |
| <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of Smell/Taste | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Conditions | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> None of the Above |
| <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Muscle Cramps/Spasms | <input type="checkbox"/> Other: |

Family History: Has any blood relative been diagnosed with any of the following conditions? Consider at least 3 generations (grandparents, parents, aunts/uncles, siblings, children, etc.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes – type I or II |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism/Drug Abuse | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Visual/Hearing Loss |

* Mark on the scale below your level of pain. (0-no pain, 10-fully debilitating) *



* Have you seen another provider for this condition? YES NO Who? _____

* Circle any testing procedures you have had for this condition? X-rays MRI Labs Other

* List your treatment goals and rate your commitment to improving your health on a scale of 0 to 10 (0-none, 10-high) _____

* Using the diagram below, show where you feel symptoms and use the extra space for any additional information you wish to provide.



QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.