balance

ABOUT YOU

Patient Name _____ **Date of Birth** _____

What do you preferred to be called? _____ **Referred By:** _____

Gender ☐ Male ☐ Female ☐ Non-Binary **Pref. Language** _____ **Race** ☐ White ☐ African American

☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Other _____

Mailing Address _____ **City** _____ **State** _____ **ZIP** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Appointment Reminder ☐ Text 1 day before ☐ Email 1 day before ☐ No Reminder

Employer _____ **Occupation** _____ **How long?** _____

Status ☐ Minor ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Widow/Widower

How many children do you have? _____ **Ages** _____

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____ **Relation** _____

Home Phone _____ **Work Phone** _____

REASON FOR VISIT

Please tell us your primary complaint:

☐ Neck ☐ Back ☐ Shoulder ☐ Hip ☐ Foot ☐ Knee ☐ Hand ☐ Head

When did condition begin? _____

The reason for this visit is a result of:

☐ Work ☐ Sports ☐ Chronic ☐ Trauma ☐ Auto ☐ Unsure

Describe type of pain (Select all that apply)

☐ Sharp ☐ Radiating ☐ Stabbing ☐ Aching ☐ Dull ☐ Burning ☐ Throbbing ☐ Nagging

What is the frequency?

☐ Infrequent ☐ Occasional ☐ Frequent ☐ Constant

What aggravates it? (Select all that apply)

☐ Bending ☐ Twisting ☐ Pushing or Pulling ☐ Prolonged standing ☐ Prolonged sitting

☐ Walking ☐ Running ☐ Overhead movements ☐ Sleeping position ☐ Carrying or Lifting

☐ Exercising ☐ Driving ☐ Getting in/out of chair Other: _____

What helps relieve it? (Select all that apply)

☐ Lying down on back ☐ Topical (Topricin,CBD, Etc.) ☐ Exercise ☐ Lying down on side/stomach ☐ Heat

☐ Standing ☐ Sitting ☐ Stretching ☐ Massage/soft tissue work ☐ Ice

☐ OTC pain meds ☐ Acupuncture ☐ Meditation ☐ Avoiding aggravating positions

☐ Physical Therapy ☐ Chiropractic Spinal Manipulation Other: _____

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If yes, please explain _____

Do you exercise? ☐ No ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-7 times/week

Type of exercise? ☐ Cardiovascular ☐ Stretching ☐ Strengthening ☐ Type of sports

What is your present general stress level? ☐ None ☐ Minimal ☐ Moderate ☐ Greatly stressed

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PAST OR PRESENT SYMPTOMS, CONDITIONS OR HABITS

Symptoms	Past	Present	Symptoms	Past	Present	Symptoms	Past	Present
Neck pain	☐	☐	Shoulder pain	☐	☐	Arm pain	☐	☐
Hand pain	☐	☐	Upper back pain	☐	☐	Lower back pain	☐	☐
Hip pain	☐	☐	Knee pain	☐	☐	Ankle pain	☐	☐
Foot pain	☐	☐	Jaw pain	☐	☐	Stiffness	☐	☐
Headaches	☐	☐	Dizziness	☐	☐	Fainting	☐	☐
Convulsions	☐	☐	Fatigue	☐	☐	High blood pressure	☐	☐
Heart Condition	☐	☐	Respiratory	☐	☐	Digestive	☐	☐
Kidney	☐	☐	Bladder	☐	☐	Sinus	☐	☐
Allergies	☐	☐	Asthma	☐	☐	Cancer	☐	☐
Stroke	☐	☐	Skin Condition	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Prostate	☐	☐	Uterus	☐	☐
Ovaries	☐	☐	Menstrual	☐	☐	Breast Soreness	☐	☐

Habits	Past	Present	Occasional	Moderate	Heavy
Tobacco use	☐	☐	☐	☐	☐
Alcohol use	☐	☐	☐	☐	☐
Caffeine use	☐	☐	☐	☐	☐

Conditions	Past	Present
Pregnancy	☐	☐
Surgery	☐	☐

Please list _____

MEDICINE TAKEN FOR CURRENT COMPLAINT

☐ Insulin ☐Muscle relaxers ☐ Stimulants ☐ Pain killers (include Aspirin)
☐Tranquilizers ☐ Blood thinners ☐ Other_____

What RX Medications are you taking? _____

Do you have allergies to any medications? ☐ Yes ☐ No

If yes, please list and describe reaction_____

Have you had any imaging done that relates to your complaint?

☐ MRI ☐ X-ray ☐ Ultrasound ☐ CT Scan

Other:_____

INSURANCE INFO

Carrier Name _____

Note: If you have insurance, please bring your card.

FAMILY HISTORY

Please indicate if a close family member has had any one of the following diseases:

Symptoms	**Past**	**Present**
Alcoholism	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Epilepsy	☐	☐
Pneumonia	☐	☐
Diabetes	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Cancer	☐	☐
Headache	☐	☐
Thyroid	☐	☐
Gout	☐	☐
Kidney	☐	☐
Liver	☐	☐

Other _____

What are your primary goals for treatment?

_____

_____

Depending on your specific goals and needs, communication between your other medical practitioners could benefit you. Please let us know who your Primary Care Provider is and any other practitioner you see that you would like us to collaborate your care with.

_____

Is there anything else the doctor should know about your current condition, your progress or ways your current condition is affecting your life?

_____

_____

FOR DOCTORS USE ONLY

I have reviewed the information contained on this form with the patient

Provider Initials_____

Date _____

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. I give permission for Dr. Miles to examine me as he deems necessary, and I give authority for these procedures to be performed

Signature of Patient or Guardian_____ Date_____

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