Balanced Health Chiropractic Center of West Michigan, PLC

300 S State Street / Suite # 4/ Zeeland, MI 49464 // (616) 772-9255 //

Legal Name:
Address:
City/State/Zip:
Cell Phone: Work Phone:
Birth Date: Social Security Number: - -
Email Address: Marital Status: M W D S
Occupation: Employer:
Spouse's Name: Children? If so, how many:
When did you last see a chiropractor? Dr.:
How did you hear about us?
Are you here for a recent auto or work injury? Y/N Date of Accident?
Other doctors you've seen recently:
Medicines that you take:
Vitamins/Supplements that you take:
Surgeries you've had (circle all that apply; write in others): hysterectomy, appendectomy, gall bladder, tonsils, c-section, cataracts, knee, hip, back
Are you pregnant or nursing?
Who is financially responsible for this bill?
Method of payment: [ ] Cash [ ] Check [ ] Credit Card [ ] Insurance
Emergency Contact: Phone Number:
Would you like text reminders about your appointments? Y/N Cell Carrier:

A large number of our patients have experienced many of the type of impacts that could cause vertebral subluxation. Help us discover a few of yours:

1. How many total auto accidents have you been in?
   i. 5+ 3-4 1-2 0
2. Which of the following sports have you been involved in? (Please circle)
   a. Football, basketball, soccer, field hockey, gymnastics, horseback riding, martial arts, rollerblading
3. Have you ever….. [ ] fallen down stairs [ ] slipped on ice or snow
   [ ] had a stress or strain while working [ ] sports injury
4. Do you….. [ ] sit more than 4 hours a day [ ] drive more than two hours per day

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What activities would you like to do that your health is impairing you from doing?

How would your life change if you had optimal health?

What needs to happen for you to have optimal health and healing?

Nature of condition: Initial onset within last 3 months Multiple episodes Continuous

Date symptoms began on:

Briefly describe current symptoms:

_____

_____

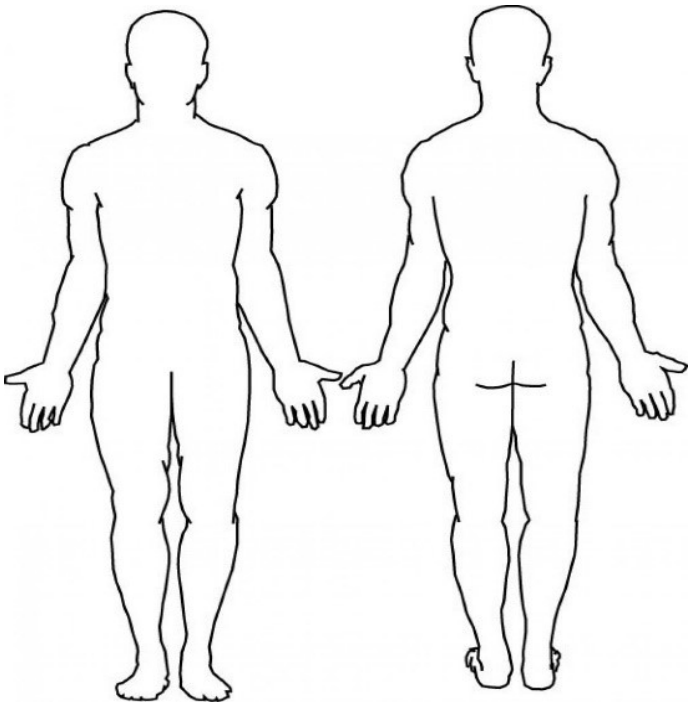
How did each of these symptoms start?

_____

How much have your symptoms interfered with your usual daily activities? (including work outside the home and housework)
[ ] Not at all [ ] A little bit [ ] Moderately
[ ] Quite a bit [ ] Extremely

How often do you experience your symptoms?
Past week [ ] (75-100% of the time) [ ] (51-75% of the time) [ ] (26-50% of the time) [ ] (0-25% of the time)
Last 24 hours [ ] (75-100% of the time) [ ] (51-75% of the time) [ ] (26-50% of the time) [ ] (0-25% of the time)

On a scale of 1-10, how would you rate your pain?
1 2 3 4 5 6 7 8 9 10



Please indicate where you experience symptoms

Patient Signature:_____Date:_____