Balanced Chiropractic and Nutrition
My guide to wellness

Medical History Information

First Name: | Middle: | Last: | Nickname:

Spouse's Name: | Email:

Do you have children? ☐ Yes ☐ No Ages: _____ _____ _____ _____ _____

Address: | City: | State: | Zip:

Home Phone: | Work Phone: | Cell Phone:

Sex: Male / Female Date of Birth: Age: Height: Weight: Right / Left Handed

Emergency Contact Name: Relationship: Phone: Do you have Insurance? ☐ Yes ☐ No

Employment (circle)
Employed Homemaker Student P/T F/T
Child Retired Disabled

Occupation: | Employer:

Marital status (circle one)
Single / Mar / Div / Sep / Widowed

Referred by: | Other family members seen here:

How would you like us to contact you for future appointments: ☐ Cell Phone ☐ Home phone ☐ Work phone ☐ Email

Medical Care Information

Do You Have a Family Doctor/Primary Care Physician? ☐ Yes ☐ No
If Yes, would you like to have a copy of your report for this visit sent to your PCP? ☐ Yes ☐ No

Name of Family Doctor: Date of last Visit: Date of last exam:

Street: City: State: ZIP Code:

Have you Had Surgeries in the last 5 Years: ☐ Yes ☐ No

Reason for Surgery:

Current Condition

The reason for this visit:

When did this condition begin? | Is this condition getting worse? ☐ Yes ☐ No | The pain/discomfort... ☐ is constant ☐ comes & goes

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No
If so, who, when & where? Phone#

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No Was it for the current condition? ☐ Yes ☐ No
If so, who, when & where?____ Phone: ____________________

Goals For My Care:

People see healthcare practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction maybe. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we maybe guided by your wishes.

☐ **Corrective Care**- Correcting and relieving the cause of the problem as well as the symptoms
☐ **Relief Care**- Symptomatic relief of pain or discomfort
☐ **Comprehensive Care**-Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible

Please check the services you are interested in receiving or acquiring more information:
☐ Chiropractic ☐ Acupuncture ☐ Neuro Emotional Technique ☐ Empowerment Coaching ☐ Massage ☐ Cold Laser ☐ Orthotics ☐ Immune Support
☐ Detox Footbaths ☐ Nutritional Assessment/Counseling ☐ Genetic Test ☐ Spectra cell: Mineral/Vitamin Def, Thyroid Adrenal panel, Cardiac Panel, Hormone
☐ Elisa Act: Food/Chemical Sensitivities ☐ Body Composition: Food & calorie requirement, exercise requirements

Present Illness /Conditions:

☐ AIDS / HIV	☐ Bone fracture	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ Diverticulitis/Crohn's /IBS	
☐ Allergies	☐ Scars	☐ Pacemaker	☐ High blood pressure	☐ Thyroid trouble	☐ Mental/Emotional Difficulty	
☐ Anemia	☐ Diabetes	☐ Prostate trouble	☐ Low blood pressure	☐ Tuberculosis	☐ Epilepsy/Seizure	
☐ Arthritis	☐ HIV/ARC	☐ Kidney trouble	☐ Rheumatic fever	☐ Hives/Rashes	☐ Eating Disorder	
☐ Asthma	☐ Eczema	☐ Dislocated joints	☐ Scoliosis	☐ Cirrhosis/hepatitis	☐ Ulcer	☐ Acid Reflux
☐ Cancer	☐ Hay Fever	☐ Psoriasis	☐ Sinus trouble	☐ Gall Bladder	☐ Polio	☐ Heartburn
☐ Headache	☐ Migraine	☐ Hypoglycemia	☐ Frequent Urination	☐ Gout	☐ STD'S	☐ Genetic issue

Prescriptions:

NUTRITIONAL SUPPLEMENTS / HERBS / HOMEOPATHIC:

SLEEP:

☐ Wake up rested	☐ Wake up rested, but energy drops after: Breakfast mid-morning Lunch mid-afternoon Dinner	☐ 2nd wind if you stay up past bedtime	Sleep: 6hrs, 7hrs, 8hrs, 9hrs Other____________
☐ Wake up exhausted	☐ Wake up during the night	☐ Wake up in the middle of the night to Urinate	☐ Wake up in the middle of the night hungry

☐ No energy all day	☐ Hard to fall to sleep	☐ Easy to fall asleep	☐ Difficult to fall back to sleep	☐ Easy to fall back to sleep
☐ Unable to relax enough to fall asleep ☐ Thinking ☐ Stress ☐ Worry ☐ Pain ☐ Tightness		☐ Unable to stay asleep	☐ Wake up in pain	☐ Night Sweats

Other:

FAMILY HISTORY OF ILLNESS:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ Scoliosis	☐ Dislocated joints
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Cirrhosis/hepatitis
☐ Anemia	☐ Epilepsy	☐ HIV/ARC	☐ High blood pressure	☐ Polio	☐ Mental/ Emotional Difficulty
☐ Arthritis	☐ Diabetes	☐ Gout	☐ Prostate trouble	☐ Thyroid trouble	☐ Diverticulitis /Crohn's /IBS
☐ Asthma	☐ Ulcer	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Migraine

Other:

TYPE OF CANCER: ☐ Breast ☐ Lung ☐ Prostate ☐ Other:

SOCIAL HISTORY:

☐ Caffeine Use _______oz/day	☐ Exercise ____ hours/wk ☐ Cardio ☐ Weights ☐ Yoga	☐ Orthotics / Shoe Insert

☐ Alcohol Consumption drinks/wk ☐Beer ☐Wine ☐Liquor

☐ Tobacco Use _______packs/day

Diet
☐ Vegetarian Type : _________________________________ ☐ Autoimmune Protocol
☐ Paleo ☐ Low Carb ☐ High Carb ☐ Low Sodium ☐ Gluten Free ☐ Lactose / Casein Free

☐ Sweeteners
☐ Sugar ☐ Agave ☐ Stevia ☐ Palm sugar ☐ Honey ☐ Sucanat ☐ Monk Fruit
☐ Splenda ☐ Equal ☐ Sweet'N Low ☐ Xylitol ☐ Erythritol ☐ Swerve

Type of Mattress: ______________

Age of Mattress: _______

FEMALE REPRODUCTIVE HISTORY:

Age menses began:	Regular monthly period: ☐ Yes ☐No	How heavy is your bleeding? ☐ Light ☐ Normal ☐ Heavy
Date of last period:	☐ 21 days ☐ 28 days ☐ 35 days	
Last Pap smear:		Blood Color: ☐ Light-red ☐ Red ☐ Dark Red ☐ Purple ☐ Brown ☐ Black
Painful periods? ☐ Yes ☐No How many days of pain? :	☐ Other:	

☐ Acne before or during cycle	☐ Clotting	☐ Uterine Fibroids	☐ Uterine Prolapse	☐ Pain during ovulation
☐ Breast tenderness	☐ PMS	☐ Ovarian Fibroids	☐ Retroverted Uterus	☐ Pain during sex
☐ Spotting / Breakthrough bleeding	☐ PMDD	☐ Polyps	☐ Endometriosis	☐ Pelvic Inflammatory Disease
☐ Polycystic Ovarian Syndrome	☐ HRT	☐ Genital Herpes	☐ Fertility drugs	☐ Pelvic Adhesions
☐ Recurring Yeast Infections	☐ HPV	☐ Chlamydia	☐	☐ Pelvic Abnormalities
☐ Chronic Vaginal discharge	☐ STDs	☐ Abnormal Pap smear	Hysterectomy?	☐ Pelvic Pain
☐ Cervical Biopsy/Cauterization/Conization	☐ D & C	☐ Yeast Infections		☐ Chronic Discharge
# of Pregnancies:	# of Miscarriages:		☐ partial (Lt / Rt Ovary) ☐ full	☐

PREGNANCY HISTORY:

☐ Constipation ☐ Diarrhea ☐ Yeast Infections ☐ Other____
☐ Allergies ☐ Rashes ☐ Hives ☐Psoriasis ☐ Eczema ☐ Other____
☐ Antibiotics during delivery ☐ rH factor (rhogam shot) ☐ Antibiotics during pregnancy ☐ Positive Beta Strep ☐ Flu Shot ________
☐ Gestational Diabetes ☐ Bed Rest ☐ Early Labor ☐ Induced Labor ☐ C-section ☐ Delivery at week --34, 35, 36, 37, 38, 39, 40

CHILDREN'S HISTORY:

☐ Constipation ☐ Diarrhea ☐ Abnormally large bowel movements ☐ Colic ☐ Pain after eating ☐ Reflux / spitting up ☐ Bloating after eating
☐ Rashes ☐ Hives ☐Psoriasis ☐ Eczema ☐ Other____
☐ Inability to make eye contact ☐ Delayed language ☐ Difficulty expressing themselves ☐ Jumbled word pronunciation ☐ Anger outbursts ☐ Aggression
☐ Food Sensitivities ------☐ Dairy ☐ Wheat/Gluten ☐ Sugar ☐ Food Coloring ☐ Other ___________________________________
☐ Dyslexia ☐ Hard time focusing ☐ Hard time focusing to read ☐ Hard time learning math
☐ Banging/hitting head ☐ Hitting stomach ☐ Toe Walking ☐ Flapping
☐ Disliked tummy time ☐ Skipped crawling ☐ "Crab" crawling ☐ Early walking ☐ Started crawling at age ________ ☐ Started walking at age ________
☐ ADD ☐ ADHD ☐ PDD ☐ ODD ☐ Autism ☐ Asperger's ☐ Other___________________________ ☐ Are they expressive- smile and laugh when appropriate?
☐ Vaccinated ☐ Delayed schedule ☐ Current ☐ Vaccine Injury ☐ Other concerns: ____

Patient Signature: ____ **Printed Name:** __________________________________ **Date:** _________________

Guardian Signature: ____ **Printed Name:** __________________________________ **Date:** _________________

Balanced Chiropractic and Nutrition, PA 5309 Williams Drive Corpus Christi, TX 78411 361-991-4672 FAX: 361-991-4673