



Welcome! It is our pleasure to welcome you to Balance Family Chiropractic. To help us serve you better, please complete the following information. Please note, there are 2 PAGES to this form!! We look forward to working with you to build better health for you and your family.

Name: _____

Date: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Home phone #: _____ Work phone #: _____

Birth date: _____ Occupation: _____

Who may we thank for referring you? _____

What is the **main** reason for consulting our office today? _____

Has this problem occurred before? **Y or N** If so, when? _____

List, in order of importance, any other health challenges that concern you:

- 1) _____
- 2) _____

Do any of these conditions interfere with (please circle):

Sleep Daily Activities Exercise Walking Sitting Lifting

Does anything make it feel better (**please list**): _____

Previous chiropractic experience? **Y or N**

Name of Chiropractor _____ Date of last adjustment? _____

List all falls, accidents or injuries you have had and give approximate dates:

Have you ever been hospitalized? **Y or N** if yes, when? _____

Have you ever had x-rays done? **Y or N** if yes, when? _____

Please list the 3 most stressful events in your life:

- 1) _____ date: _____
- 2) _____ date: _____
- 3) _____ date: _____

Are any of these situations continuing to impact your life? _____

When is the last time you felt at your best? _____

Please list any current medications: _____

How many hours of sleep do you get per night? _____ Do you use 1 or 2 pillows? _____

Rate your commitment to gain optimal health. **Scale of 1-10** _____

How would you describe your nutritional intake? Excellent Good Fair Poor
How do you describe your physical health? Excellent Good Fair Poor Working on it
Do you participate in exercise? _____ How often? _____

Which of the following do you use (how much, how often, how long)?

Vitamins or Supplements: _____

Caffeine: _____ Tobacco: _____ Alcohol: _____

Do you work with any chemical, fume, dust, powder, vibration or smoke for prolonged periods? **Y or N**

If yes, please describe: _____

Occupational stress (1-10, 10 being **most** stressful): _____

Do you have children? **Y or N**

If so, please list names and ages: _____

Please list any health concerns of children: _____

Please describe the health status of your mother: _____

Please describe the health status of your father: _____

Please **circle** any of the following that are affecting your health:

Gas or bloating after meals	visual problems	forgetfulness
Constipation	ear aches	nervousness
Diarrhea	fatigue	numbness
Nausea	loss of sleep	shortness of breath
Excessive thirst	allergies	
Poor/excessive appetite	irregular heart beat	
Weight trouble	dizziness	

Females: Do you suffer from menstrual (**please circle**): cramping irregularity pain
Date of Last period: _____ Are you pregnant? YES NO MAYBE

Is there anything we need to know before we begin your chiropractic care? _____

I give my consent for Dr. Jennifer Murray or her designate to perform a full and comprehensive examination on me which may include case history, thermal scan, posture analysis, x-ray and/or hands on chiropractic spinal exam.

Patient Signature

Date