BALANCE FAMILY CHIROPRACTIC

Dr. Jennifer Murray
102-12840 Yonge Street, Oak Ridges, ON L4E-4H1 905.773.5165

Welcome to Balance Family Chiropractic. To help us serve you better, please provide us with the following information. Please note, there are 2 PAGES to this form!! We look forward to working with you.

Name: _____
Date: _____ Gender: Male Female
Address: _____ City: _____
Postal Code: _____ Email: _____
Home phone #: _____ Work phone #: _____
Birth date: _____ Occupation: _____
How did you hear about us? (**please circle one**)
Website Advertising Personal referral:_____

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**): _____

Name of Family Doctor _____

Previous chiropractic experience? **Y or N**
Name of Chiropractor _____ Date of last adjustment? _____

List all falls, accidents or injuries you have ever 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:_____

BALANCE FAMILY CHIROPRACTIC

Dr. Jennifer Murray
102-12840 Yonge Street, Oak Ridges, ON L4E-4H1 905.773.5165

PATIENT NAME:_____

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: _____

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	Weight trouble
Poor/excessive appetite	irregular heart beat	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? _____
_____

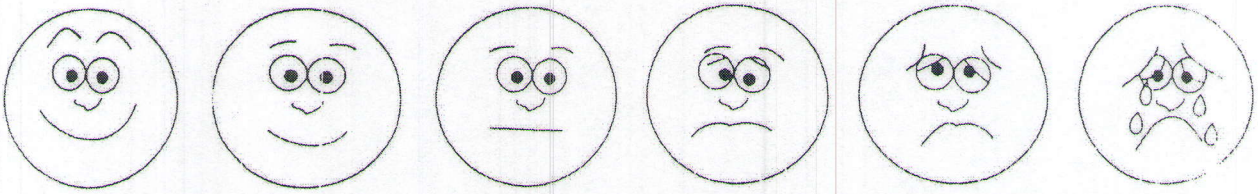
I give my consent for Dr. Jennifer Murray or her designate to perform a full and comprehensive examination on me which may include case history, thermal scan, posture analysis and hands on chiropractic spinal/joint exam. I clearly understand and agree that I am personally responsible for payment of all fees charged by Balance Family Chiropractic and I understand that my personal information will be kept confidential in accordance with the privacy legislation.

_____ _____
Patient Signature Date

Faces and Visual Analog Pain Scales

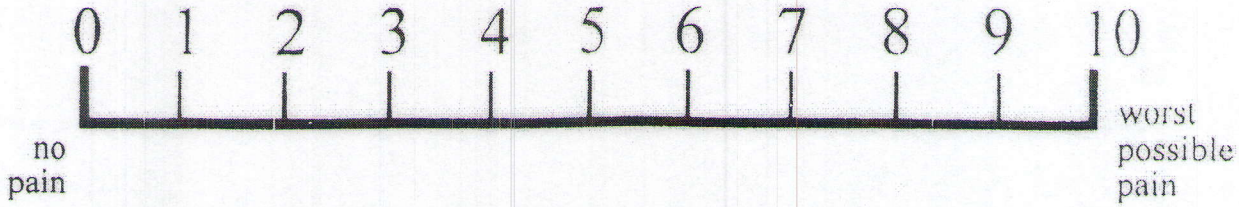
Please circle the number and/or the face that best refers to your level of pain (or lack thereof!) today. Please sign and date.

Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Visual Analog Scale (VAS)



Date: _____

Signature: _____

BALANCE
FAMILY CHIROPRACTIC
12840 Yonge Street – Suite 102, Oak Ridges, Ontario, L4E 4H1 905-773-5165

Foot Pain? Knee Pain? Take our Quiz!

		Circle One	
1.	Do you have pain on the bottom of your foot/feet?	YES	NO
2.	Do you have pain when you get up in the night or first thing in the morning?	YES	NO
		YES	NO
3.	Do you have heel pain?	YES	NO
4.	Has anyone told you that you have flat feet?	YES	NO
5.	Do you have bunions? (bony projections on the sides of your great toe?	YES	NO
6.	Does your great toe deviate (go towards) your baby toe?	YES	NO
7.	Do you have calluses on the side of your great toes?	YES	NO
8.	Have you had an ingrown toenail?	YES	NO
9.	Do you wear high heel frequently?	YES	NO
10.	Do you have knee pain?	YES	NO
11.	Is there pain on the inside or underside of your kneecap?	YES	NO
12.	Do you hear "crackling" in your knee when you bed?	YES	NO
13.	Have you had a broken leg or ankle that has left you with unequal leg lengths?	YES	NO
14.	Are you overweight?	YES	NO
15.	Do you have back pain?	YES	NO

If you answered "yes" to 3 or more of these questions, you may benefit from a prescription foot orthotic. A foot orthotic is a thin, soft, custom-fitted insert that goes directly into your shoe.

A prescription foot orthotic helps bring foot muscles and bones back into proper alignment, the same way braces do for teeth. Orthotics help restore the normal balance and alignment of your body and bring relief from pain and fatigue. They work so naturally that you will want to wear them as much as possible.