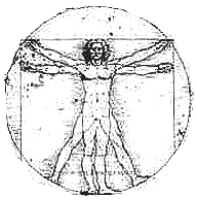


Balance Chiropractic, P.C.
Dr. Jim Neilson
477 NE Revere Ave. • Bend, OR 97701 • Phone 541-383-5156

Date:_____

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name:_____
Last Name First Name Initial

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Cell Phone:_____ Business Phone:_____

Sex: ❑ M ❑ F Age: _____ Birthday: _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient employed by: _____ Occupation: _____

Whom may we thank for referring you?_____

Notify in case of emergency?_____ Home Phone:_____

Cell Phone _____ Business Phone:_____

Health History

Please list any serious injuries or surgeries you have had.

	Description
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	
Other Serious Injuries	

Women: Are you pregnant or nursing? ❑ Y ❑ N Do you use oral contraceptives? ❑ Y ❑ N

Habits

	none	light	mod.	heavy
Alcohol	❑	❒	❒	❒
Caffeine	❑	❒	❒	❒
Tobacco	❑	❒	❒	❒
Drugs	❑	❒	❒	❒
Exercise	❑	❒	❒	❒
Sleep	❑	❒	❒	❒
Soft Drinks	❑	❒	❒	❒
Water	❑	❒	❒	❒
Sugar	❑	❒	❒	❒
Fast Food	❑	❒	❒	❒

Medical Conditions

Check (✓) yes or no whether you have had or currently have any of the following medical conditions:

❑ Y ❑ N Heart Attack/Stroke
❑ Y ❑ N Congenital Heart Defect
❑ Y ❑ N Alcohol/Drug Abuse
❑ Y ❑ N Fainting/Seizures/Epilepsy
❑ Y ❑ N Shingles
❑ Y ❑ N Psychiatric Problems
❑ Y ❑ N Difficulty Breathing
❑ Y ❑ N Hepatitis
❑ Y ❑ N Anemia
❑ Y ❑ N Food Allergies
❑ Y ❑ N Diabetes
❑ Y ❑ N Herpes
❑ Y ❑ N Anxiety

❑ Y ❑ N Material Allergies (latex, wool, metal, chemicals)
Other: _____
❑ Y ❑ N Arthritis
❑ Y ❑ N Frequent Neck Pain
❑ Y ❑ N Jaw Pain
❑ Y ❑ N Wrist Pain
❑ Y ❑ N Shoulder Pain
❑ Y ❑ N Arm Pain
❑ Y ❑ N Leg Pain
❑ Y ❑ N Migraines
❑ Y ❑ N Constipation
❑ Y ❑ N Fatigue

❑ Y ❑ N Lower Back Problems
❑ Y ❑ N Severe/Frequent Earaches
❑ Y ❑ N Ringing in Ears
❑ Y ❑ N Severe/Frequent Headaches
❑ Y ❑ N Diabetes/Tuberculosis
❑ Y ❑ N Dizziness
❑ Y ❑ N Emphysema/Glaucoma
❑ Y ❑ N Kidney Problems
❑ Y ❑ N Artificial Bones/Joints
❑ Y ❑ N High Blood Pressure
❑ Y ❑ N Digestive Problems
❑ Y ❑ N Gum Problems

❑ Y ❑ N Cancer
❑ Y ❑ N HIV Positive/AIDS
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Gout
❑ Y ❑ N Numbness, where?
_____
❑ Y ❑ N Tingling, where?
_____
❑ Y ❑ N Muscle Spasms, Where? _____
❑ Y ❑ N Sciatica
❑ Y ❑ N Depression

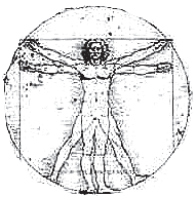
List medications/supplements you are currently taking, if any:

_____
_____
_____

List drug allergies, if any:

_____
_____
_____

* Please complete both sides.



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Family History

If any blood relative has had any of the following conditions, please check (✓) and indicate which relative(s)

❑ Alcoholism	❑ Cancer	❑ High blood pressure
❑ Anemia	❑ Diabetes	❑ High cholesterol
❑ Arteriosclerosis	❑ Emphysema	❑ Multiple sclerosis
❑ Arthritis	❑ Epilepsy	❑ Osteoporosis
❑ Asthma	❑ Glaucoma	❑ Stroke
❑ Bleed easily	❑ Heart disease	❑ Thyroid disease

Reason for Visit

Have you ever seen a chiropractor? ❑ Y ❑ N If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your pain and it's location: _____

_____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ❑ Worse ❑ Better ❑ Same ❑ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ❑ Sitting ❑ Walking ❑ Bending ❑ Lying down ❑ Lifting

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Aching ❑ Burning ❑ Cramping ❑ Numbness ❑ Tingling
❑ Stiffness ❑ Swelling ❑ Other: _____

Is pain interfering with: ❑ Work ❑ Daily Routine ❑ Sleep ❑ Recreation

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid or not by insurance.

Payment & Insurance: I understand that payment is expected at time of visit and that the office accepts cash, checks and some credit & debit cards. I understand that my insurance can be billed if confirmation of coverage can be confirmed. If coverage cannot be confirmed, payment must be made in full at the time of the visit. I understand that insurance billing is a courtesy service that may be withdrawn at anytime and that I am ultimately responsible for all charges incurred.

Cancellation Policy: I understand that this office has a 24-hour cancellation policy, and that if I must cancel my appointment, I will give at least a 24-hour notice. I understand that without a 24-hour notice, I may be charged a missed appointment fee.

Signature: _____ Date: _____