Patient Health Survey

Balance Chiropractic & Rehab
300 45th St S#315, Fargo, ND 58103

About You

Name:

Address:

City: State:

Zip Code: Home Phone:

Cell Phone:

Email Address:

Date of Birth: Age:

Social Security Number:

Gender Female Number of Children Marital Status ◯ Divorced ◯ Married ◯ Single ◯ Widowed

Employer Name:

Employer Address:

Employer City: Employer State:

Employer Zip Code: Work Phone:

Position/Title:

How did you hear about us?

Who referred you to our office?

Have you seen or heard of our office because of (check all that apply):

◯ Newspaper ◯ Sign ◯ dex ◯ smartsearch
◯ Community Event ◯ Mailing ◯ website
◯ Facebook ◯ other

Have you been treated by a chiropractor before? ◯ Yes ◯ No

If yes, what was the reason for the visit?

Approximate date of last visit?

Health Habits

Do you smoke? ◯ Yes ◯ No

Do you drink alcohol? ◯ Yes ◯ No

Do you drink coffee, tea or soda? How much? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you wear? ◯ Heal lifts ◯ Sole lifts? ◯ Inner soles ◯ Arch supports

Reason for the visit

Describe the reason for this visit:

Goal of visit: Goal of treatment:

Is the purpose of this appointment related to:

◯ Job ◯ Sports ◯ Auto ◯ Fall ◯ Home Injury ◯ Chronic Discomfort ◯ Other Please explain:

If job related, have you made a report of your accident to your employer? Yes ◯ No ◯

When did this condition begin? Has this condition: ◯ Gotten worse ◯ Stayed constant ◯ Come and gone

Does this condition interfere with? ◯ Work ◯ Sleep ◯ Daily routine ◯ Other activities

Please explain:

Has this condition occurred before? ◯ Yes ◯ No Please explain:

Have you seen other doctors for this condition? ◯ Yes ◯ No **Primary Doctors Name:**

Clinic Name:

Type of treatment: Results:

Full Name

Height	
Weight	
Age	
Date	

Have you ever (at any time) experienced any of the following?

Difficulty urinating	Yes	No	Claustrophobia (fear of small spaces)	Yes	No
Loss of bladder control	Yes	No	Spinal surgery	Yes	No
Loss of bowel control	Yes	No	Common cold/flu	Yes	No
Temporary loss of vision, one eye	Yes	No	Carotid artery surgery	Yes	No
Blood in urine	Yes	No	Breast removal	Yes	No

Have you ever been diagnosed with or told you have one of the following?

Detached retina	Yes	No	Rheumatoid arthritis	Yes	No
Stroke	Yes	No	Fractured/broken vertebra	Yes	No
Slipped disc	Yes	No	Bleeding disorders	Yes	No
Herniated disc	Yes	No	High blood pressure	Yes	No
Osteoporosis	Yes	No	Blood in stool	Yes	No
TIA's (pin or mini strokes)	Yes	No	Cancer	Yes	No
Drop attacks (collapsing, but not fainting)	Yes	No	AIDS	Yes	No
Hardening of the arteries	Yes	No	Kidney disease	Yes	No
Partial or complete paralysis	Yes	No	Prostate disease	Yes	No

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Yes	No	Memory loss	Yes	No
Vomiting	Yes	No	Fever	Yes	No
Vertigo (spinning)	Yes	No	Recurrent headaches	Yes	No
Difficulty walking	Yes	No	Diarrhea	Yes	No
Incoordination	Yes	No	Skin rash/infection	Yes	No
Loss of consciousness	Yes	No	A major fall	Yes	No
Double vision	Yes	No	A minor fall	Yes	No
Blurred vision	Yes	No	An auto accident	Yes	No
Speech problems	Yes	No	A work injury	Yes	No
Clumsiness	Yes	No	Head trauma	Yes	No
Loss of strength	Yes	No	Tinnitus (ringing in ears)	Yes	No
Abnormal menstruation	Yes	No	Painful bowel movements	Yes	No

Numbness or other sensory complaints Yes No

Medication you take

Medications

Medication Allergies

Health Conditions

Instructions: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect your customized care plan and the possibility of being accepted for care.

- ☐ Severe or Frequent Headaches
- ☐ Heart Surgery/Pacemaker
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Pain Between Shoulders
- ☐ Congenital Heart Defect
- ☐ Frequent Neck Pain
- ☐ Thyroid Problems
- ☐ Sinus Problems
- ☐ Hepatitis
- ☐ DIfficulty Breathing
- ☐ Kidney Problems
- ☐ Dizziness
- ☐ Chemotherapy
- ☐ Rheumatic Fever
- ☐ Ulcers/Colitis
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Shingles
- ☐ Numbness
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Surgeries
- ☐ Asthma
- ☐ Loss of Sleep
- ☐ Depression/Anxiety
- ☐ Pain In Arms/Legs/Hands
- ☐ Low Blood Pressure

Your concerns

Instructions: Please check box for only the health concerns or conditions you may be experiencing now or in the past. Each area of concern relates to an area of the spine and nerve function.

- ☐ Sore throat
- ☐ Stiff neck
- ☐ Radiating arm pain
- ☐ Hand/finger numbness
- ☐ Asthma
- ☐ Allergies
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Constipation
- ☐ Colitis
- ☐ Diarrhea
- ☐ Gas Pain
- ☐ Irritable bowel
- ☐ Bladder Problems
- ☐ Menstrual problems
- ☐ Low back pain
- ☐ Leg pain or numbness
- ☐ Reproductive problems
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Sinus problems
- ☐ Allergies
- ☐ Fatigue
- ☐ Head colds
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Difficulty concentrating
- ☐ Middle back pain
- ☐ Congestion
- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Gallbladder condition
- ☐ Stomach problems
- ☐ Ulcers
- ☐ Gastritis
- ☐ Kidney problems

Health Conditions - For Women Only

Are you pregnant? ☐ Yes ☐ No

If yes, when is your due date?

Are you nursing? ☐ Yes ☐ No

Are you taking birth control? ☐ Yes ☐ No

Please check one:

Race: ○ Caucasian ○ Asian or Pacific Islander ○ African American ○ Hispanic ○ Native American or Alaskan Native

Ethnicity: ○ Non-latino ○ latino

Primary language:

Smoking history: Please check: ○ Never ○ Quit - number years smoking ____ ____ # cigs per day

○ Current smoker number years smoking ____ ____ # cigs per day

Allergies:

Blood Pressure: Has any doctor diagnosed you with Hypertension presently? ○ Yes ○ No

If Yes, describe:

Has any doctor diagnosed you with Diabetes presently? ○ Yes ○ No

If yes, what kind? ☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A 1 c > 8.0%

If you know your Hemoglobin A1c, please write it in:

Do you know your total Chlosterol? ☐ HDL ☐ LDL

Have you had an X-Ray or CT scan or MRI of your low back or spine within the past 28 days? ○ Yes ○ No

Communication Authorization

May we leave appointment information or messages with the person that answers the phone? ○ Yes ○ No

May we leave appointment information or messages on your answering machine? ○ Yes ○ No

May we send appointment information or messages to your email address? ○ Yes ○ No

May we text appointment reminders/information to your cell phone? ○ Yes ○ No

Contact

With whom may we discuss your medical condition/billing questions and/or your child's medical condition/billing information/ questions other than yourself?

1. Phone #

2. Phone #

Signature Date:

IN CASE OF AN EMERGENCY, CONTACT:

Name Relationship:

Home Phone: Work Phone: Cell Phone: