Balance Health + Wellness
Registration & History

Patient_____

Address _____

Apartment/Unit/Suite Number _____

City/ZipCode:_____

Social Security #: _____

Date of Birth: _____

How did you hear of us? _____

PATIENT CONTACT INFORMATION

Email _____

Cell _____

Home _____

Work _____

Best time to reach you _____

Please Circle One:

Married Single Divorced Widowed Separated

Spouses Name _____

Spouses DOB _____

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____

Phone _____

INSURANCE INFORMATION

Insurance Company _____

Provider Phone _____

EMPLOYER INFORMATION

Occupation/Employer_____

Employer Address _____

Employer Phone _____

PATIENT CONDITION:

Reason for Visit:

_____

_____

When did your symptoms appear:

_____

Is this condition getting progressively worse?
*Yes*_____ *No* _____

*Comments:*_____

Rate the severity of your pain on a scale from
1 (*least pain*) **to 10** (*severe pain*) _____

Comments:_____

_____

How often do you have this pain? _____

Is it constant or does it come and go? _____

What does the pain interfere with (ex. Work) _____

Type of Pain (Please circle all that apply):

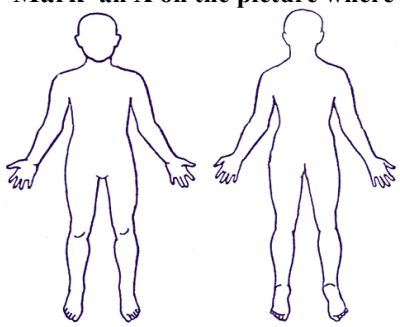
Sharp Pain	*Dull*	*Throbbing*	*Stiffness*
Numbness	*Aching*	*Burning*	*Swelling*
Shooting	*Tingling*	*Cramps*	*Other:*

Comments:_____

Activities or movements that are painful to perform:
(Please circle all that apply)

Sitting *Standing* *Walking* *Bending* *Lying Down*

***Mark an X on the picture where you experience pain:**



Comments: _____

_____

Personal History (*PLEASE PRINT*) *Date:* _____

HAVE YOU HAD? (circle choice)	Yes	N0	HAVE YOU HAD? (circle choice)	Yes	N0
Recurrent Headache			**Epilepsy**		
Eye Problem			**Seizures**		
Ear Problem			**Dizziness**		
Nose Problem			**Fainting with exercise**		
Throat Problem			**Head Injury**		
Thyroid Disorder			**Concussion**		
Heart Murmur			**Bone Injuries**		
Heart Disease			**Joint Injuries**		
Heart Palpitations			**Stomach Problems**		
High Blood Pressure			**Intestinal Problems**		
Low Blood Pressure			**Diabetes**		
Anemia			**Eating Disorder**		
Sickle Cell			**ADD**		
Bleeding Disorders: Hemophilia/Other			**ADHD**		
Hepatitis			**Chicken Pox Vaccine**		
Kidney Disorders			**Chicken Pox Illness**		
Bladder Disorders			**Mononucleosis**		
Pneumonia			**Alcoholism**		
Bronchitis			**Drug Abuse**		
Tuberculosis			**Sexual Assault**		
Seasonal Allergies/Hay Fever			**Victim of Violence**		
Asthma			**Emotional Problems-Specify below:**		
Surgeries:			**Pregnancies:**		
Hospitalizations:					

List any medications that you are allergic to?_____

List any other allergies? _____

List any medication you are currently taking?_____

Any other disease, illness, past surgeries, permanent disabilities or concerns?

_____

_____

Are you currently being treated by a health care professional? If yes, explain

_____

Please circle one in each section:

Exercise	**Work Activity**	**Habits**	
None	Sitting	Smoking	Packs/Day _____
Moderate	Standing	Alcohol	Drinks/Week _____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day _____
Heavy	Heavy Labor	High Stress Level	Reason _____