



145 Waterman Street
Lower Level
Providence, RI 02906
(401) 831-2000

WELCOME

The doctors and staff of Balance Chiropractic & Wellness Center welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Please fill out the following form in as much detail as possible.

Please print _____ Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

E-mail Address _____ Cell Phone _____

Age _____ Date of Birth _____ Occupation _____

Social Security # _____ Sex (M) (F)

Emergency Contact _____ Phone Number _____

Referred by _____

General Practitioner's name and address _____

Please list all known allergies _____

Are you presently taking any medication or over the counter products (aspirin included)? Yes _____ No _____

If yes, name them _____

Please list any previous dislocations or fractures (broken bones) and the year in which they occurred.

Please list any previous surgeries, operations and the year in which they occurred.

Have you been treated for any health condition by a physician in the past year? _____

If yes, what condition? _____

Have you ever had cancer? _____ If Yes, What kind? _____

Do you have any medical conditions not listed above? _____

Habits: (please check)

Cigarettes? _____ Quantity _____ For How Long? _____

Coffee? _____ Quantity _____

Alcohol? _____ Quantity _____ For How Long? _____

Family History

Is there a family history of any of the following:

Please indicate **who** suffered from this condition and **if they are still living**

- | | |
|------------------------------|-------------------------------|
| () High Blood Pressure | () Ulcer or Stomach Problems |
| () Heart Attack | () Stroke |
| () Kidney Disease | () Emphysema |
| () Seizure-Convulsions | () Rheumatoid Arthritis |
| () Cancer. what type? _____ | () Mental Illness |
| () Asthma | () Thyroid Disease |
| () Diabetes | () Cardiovascular Problems |
| () Other _____ | |

Have you lost or gained weight in the past year? _____

Do you have a pacemaker or any metal implants? _____

Do you take vitamins, herbs? Yes____ No ____ If yes, please list them

Do you exercise regularly? Yes ____No ____What kind of exercise? _____

Females: Date of last menstrual period _____ Children? _____

Do you have any reason to believe that you may be pregnant? Yes _____ No_____

Use this space for any additional information you may wish to discuss _____

Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose: _____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of Balance Chiropractic & Wellness Center have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. When I am accepted as a patient, I assign full benefits to Balance Chiropractic & Wellness Center, P.C. I understand that Balance Chiropractic & Wellness Center, P.C. reserves the right to charge me in the amount of \$46.00, for any missed appointments without 24 hours notice.

Date

Signature

Major complaints and symptoms — please be as specific as you can. Ask the doctor for help if you need assistance in filling out this section. _____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.

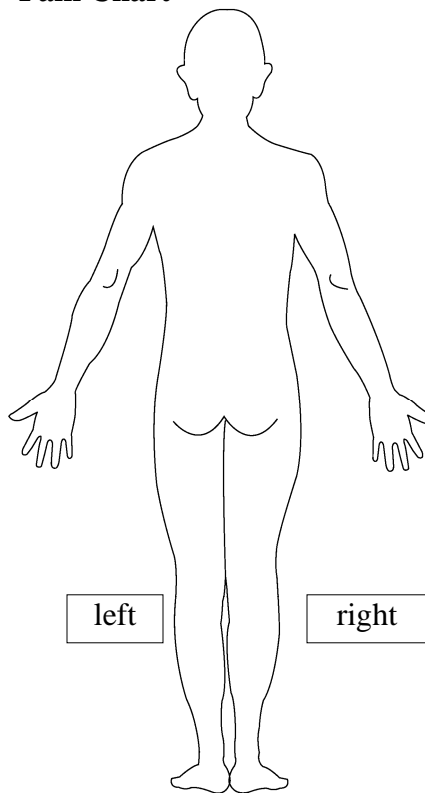
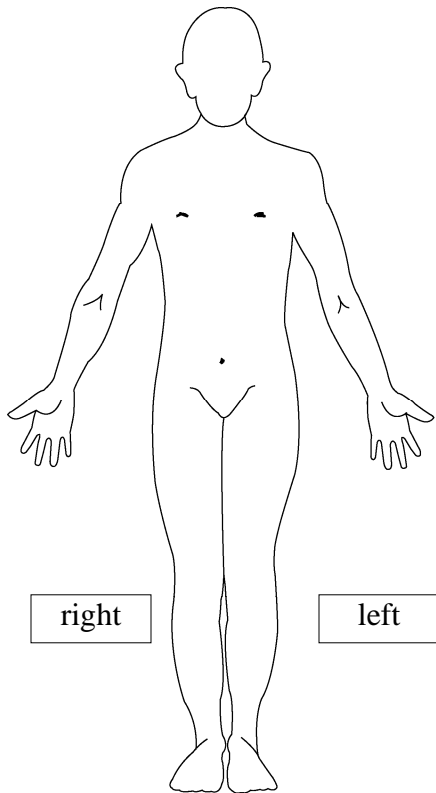
Use the appropriate symbols. Mark areas of radiation.

Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////
-----	00000	XXXXX	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
 no pain severe pain

Mid Back Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
 no pain severe pain

Low Back and Leg Pain

On a scale of zero to 10, I rate my discomfort as follows:

(_____)
0 **10**
 no pain severe pain

Date: _____

Signature _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

	Now	Past		Now	Past
	N	P		N	P
Appetite Decrease	_____	_____	Hemorrhoids	_____	_____
Arm Pain	_____	_____	Hoarseness	_____	_____
Arthritis	_____	_____	Irritability	_____	_____
Back Pain	_____	_____	Joint Swelling	_____	_____
Balance Problems	_____	_____	Knee Pain	_____	_____
Belching	_____	_____	Leg Cramps	_____	_____
Bowel Habit Change	_____	_____	Light Sensitivity	_____	_____
Chest Pains	_____	_____	Loss of Smell	_____	_____
Cold Feet	_____	_____	Loss of Taste	_____	_____
Cold Hands	_____	_____	Dark Tarry Stools	_____	_____
Constipation	_____	_____	Memory Loss	_____	_____
Depression	_____	_____	Menstrual Problems	_____	_____
Diabetes	_____	_____	Muscle Spasms	_____	_____
Diarrhea	_____	_____	Neck Pain	_____	_____
Double Vision	_____	_____	Nervousness	_____	_____
Dizziness	_____	_____	Night Sweats	_____	_____
Shortness of Breath	_____	_____	Shoulder Pain	_____	_____
Hypertension	_____	_____	Sinus Problems	_____	_____
Fatigue	_____	_____	Sleep Problems	_____	_____
Fever	_____	_____	Stiffness	_____	_____
Frequent Colds	_____	_____	Stomach Problems	_____	_____
Headache	_____	_____	Fainting	_____	_____
Heartburn	_____	_____	Tension	_____	_____
Vomiting Blood	_____	_____	Ears Ringing	_____	_____
Blood in Stools	_____	_____	Urinary Difficulty	_____	_____
Blood in Urine	_____	_____	Urinary Incontinence	_____	_____
Spitting Up Blood	_____	_____	Urinary Retention	_____	_____
			Vertigo	_____	_____

Other Symptoms _____