BACK IN BALANCE wellness center

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UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY)

○ I have new contact information.

Your Full Name

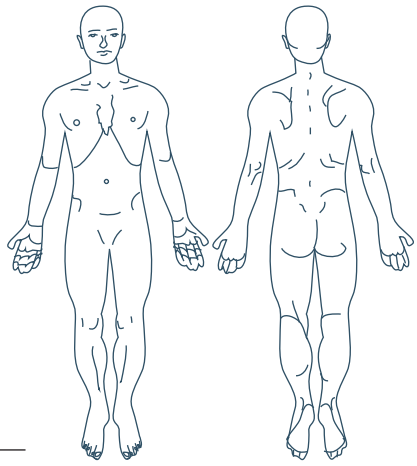
1. Onset - *When did you first notice your current symptoms?* _____

2. Intensity - *How extreme are your current symptoms?* Absent ○ Mild ○ Moderate ○ Agonizing ○

3. Duration and Timing ○ *Constant* ○ *Comes and goes*
When did it start and how often? _____

4. Quality of symptoms
What does it feel like?
- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

5. Location
Where does it hurt? Circle the area(s)



6. Radiation - *Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.*

_____

7. Aggravating or relieving factors -
What makes it better or worse (time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

8. Prior interventions - *What have you done to relieve the symptoms?*
- ○ Prescription medication
- ○ Over-the-counter drugs
- ○ Homeopathic remedies
- ○ Physical therapy
- ○ Surgery
- ○ Acupuncture
- ○ Chiropractic
- ○ Massage
- ○ Ice
- ○ Heat
- ○ Other _____

9. Activities of Daily Living - *How does this condition interfere with your life and ability to function?*

	No Effect	Mild	Moderate	Severe
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild	Moderate	Severe
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

CONSULTATION NOTES

Patient Name

Patient Number *(Office Use Only)*

This updated patient history is for:

- ○ **Current Patient Periodic Re-evaluation**
- ○ **Current Patient Additional Complaint/Exacerbation**
- ○ **Maintenance Patient** *(circle one)*
  Exacerbation
  Re-Occurrence
  New Episode
- **Inactive Patient** *(circle one)*
  Exacerbation
  Re-Occurrence
  New Episode

Doctor's Signature

Date

10. Illnesses, operations, injuries or treatment since your most recent evaluation with us:

_____

_____

_____

11. Medications - *please list all prescription and over-the-counter:* ◯ *Medication List Attached*

_____

_____

_____

SOCIAL HISTORY

12. Social History - *Tell us about your health habits and stress levels.*

Alcohol use	◯ Never	◯ Daily	◯ Weekly	How much? _____
Coffee use	◯ Never	◯ Daily	◯ Weekly	How much? _____
Tobacco use	◯ Never	◯ Daily	◯ Weekly	How much? _____
Exercising	◯ Never	◯ Daily	◯ Weekly	How much? _____
Pain relievers	◯ Never	◯ Daily	◯ Weekly	How much? _____
Soft drinks	◯ Never	◯ Daily	◯ Weekly	How much? _____
Water intake	◯ Never	◯ Daily	◯ Weekly	How much? _____

Hobbies _____

_____

Prayer or meditation?	◯ Yes ◯ No	Vaccinated?	◯ Yes ◯ No
Job pressure/stress?	◯ Yes ◯ No	Mercury filings?	◯ Yes ◯ No
Financial peace?	◯ Yes ◯ No	Recreational drugs?	◯ Yes ◯ No

13. Review of Systems - *Identify any changes since your most recent evaluation with us:*

	Worse	No change	Improved
a. Musculoskeletal - Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. Neurological- Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. Cardiovascular- Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. Respiratory- Such as asthma, apnea, emphysema, hay fever, shortness of breath pneumonia, etc.	◯	◯	◯
e. Digestive- Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. Skin- Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
g. Sensory- Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
h. Endocrine- Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. Genitourinary- Such as kidney stones, infertility, bed wetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. Constitutional- Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

14. Is there anything else we should know about your current condition, your progress or ways your current condition is affecting your life?

_____

_____

_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or causes of my health concern.

_____ _____

Signature *Date (MM/DD/YYYY)*

If the patient is a minor, print child's full name: _____

CONSULTATION NOTES

Patient Name _____

Patient Number *(Office Use Only)* _____

Doctor's Signature _____

Date _____