MOVING TOWARD

BALANCE™

1620 W. Defenbaugh St.
Kokomo, IN 46902
Phone (765) 450-8398
Fax (815) 301-3140

Office Use
Patient #: ________

PATIENT INFORMATION

Please print and answer the following questions as accurately and completely as possible.

Today's Date: ________________________________

PERSONAL INFORMATION

Legal Name: ________________________ (First) (MI) (Last) Age: ______ Sex: ☐M ☐F

Address: ________________________________

City: ________________ State: ______ Zip: ________

Home Phone: ________________ Date of Birth: ____/____/____

Business/Employer: ________________ Work Phone: ________________

Type of Work Performed: ________________ Marital Status: ☐M ☐S ☐W ☐D

Spouse's Name: ________________ Children? Sons: _____ Dau: _____

Emergency Contact: ________________ Phone: ________________

Who is Your Family Physician? ________________ City: ________ State: ______

How did you hear about this office? ________________________________

CURRENT HEALTH CONCERNS

Reason For Today's Visit: ________________________________

Is Condition: ☐ Job Related ☐ Auto Related ☐ Injury ☐ Other

PAST HEALTH HISTORY

Major Surgeries/Operations: ☐Head ☐Neck/Throat ☐Chest/Heart/Lung ☐Back ☐Abdominal ☐Other

Previous Fractures or Broken Bones: ☐ Yes ☐ No What: ________________

Previous Falls or Accidents: ☐ Yes ☐ No When: ________________

Previous Hospitalization: ☐ Yes ☐ No Why: ________________

Previous Chiropractic Care: ☐ Yes ☐ No Doctor: ________________

Previous Spinal X-rays/MRI/CT ☐ Yes ☐ No Where: ________________

Medications Now Taking:

- ☐ Pain Killers/Muscle Relaxants
- ☐ Nerve/Antidepressants
- ☐ Heart
- ☐ Blood Pressure Medication
- ☐ Antibiotics
- ☐ Insulin/Other
- ☐ Stomach Medicine
- ☐ Vitamins/Supplements
- ☐ Other: ________________________________

Below are a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, this information may affect your response to our care as well as our approach to handling your case. Please complete the following as thoroughly as possible.

Check any of the following that applies to you:

- ☐Allergies
- ☐Diabetes
- ☐Cancer
- ☐Heart Problems
- ☐Stroke
- ☐Kidney Problems
- ☐Osteo-Arthritis
- ☐Epilepsy
- ☐AIDS or ARC
- ☐Frequent Illness
- ☐Fibromyalgia
- ☐Addictions past/present
- ☐Rheumatoid Arthritis
- ☐Gout
- ☐Chronic fatigue
- ☐Lupus
- ☐ALS/MS
- ☐Parkinson's

Intake or Use:

- ☐ Alcohol
- ☐ Tobacco
- ☐ Caffeine
- ☐ Drugs of Abuse

Do you exercise regularly? ☐ Yes ☐ No **Are You Dieting?** ☐ Yes ☐ No **Since:** ___/___/___

CHECK ANY PROBLEM AREAS THAT YOU HAVE HAD IN THE PAST YEAR:

MUSCLES-SKELETON
- ☐ Low Back
- ☐ Middle Back
- ☐ Neck
- ☐ Arm(s)
- ☐ Leg(s)
- ☐ Shoulder(s)
- ☐ Knee(s)
- ☐ Jaw -TMJ
- ☐ General Stiffness

NERVE SYSTEM
- ☐ Headaches
- ☐ Nervousness
- ☐ Depression
- ☐ Numbness/Tingling
- ☐ Muscular Weakness
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions
- ☐ Stress
- ☐ Shaking/Tremors

CIRCULATION-BREATHING
- ☐ Chest
- ☐ Breathing
- ☐ Blood Pressure
- ☐ Heart
- ☐ Lungs
- ☐ Poor Circulation

DIGESTION-ELIMINATION
- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss/Gain
- ☐ Gas/Bloating
- ☐ Heartburn

MALES ONLY
- ☐ Prostate Ptoblems
- ☐ Testicular problems
- ☐ Erectyile Dysfunction

EYE-EAR-NOSE-THROAT
- ☐ Eyes
- ☐ Dental
- ☐ Throat
- ☐ Ear(s)
- ☐ Nose
- ☐ Sinus

URINARY-GENITALS
- ☐ Pain Upon Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Urine Stream
- ☐ Bladder Control

FEMALE ONLY
- ☐ Menstrual Problems
- ☐ Low Back Pain w/ Periods
- ☐ Breast Lumps/Problems

Are you pregnant?
☐ Yes ☐ No ☐ Not sure

FAMILY HEALTH HISTORY: (ie heart, cancer, stroke, diabetes, blood pressure, etc)
Mother's side: ______________________________
Father's side: ______________________________

ANY OTHER PROBLEMS NOT LISTED ABOVE:

Signature of fact, acknowledgement of Payment Policy and Receipt of Notice of Privacy Practices. I understand that my care in this office may involve the making of judgements that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge.

I understand and agree that any health or accident insurance policies that I have are an arrangement between the insurance carrier and myself and that Moving Toward Balance (MTB) is not a party to that contract. I acknowledge that Moving Toward Balance does not file insurance claims and that I am personally responsible for the payment of all services provided by Moving Toward Balance. <u>I understand that payment is due at the time services are rendered.</u> A receipt is available upon request.

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Moving Toward Balance, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the practice.

______________________________ ___/___/___
Patient's / Parent's / Legal Guardian's Signature Date