BALANCE CHIROPRACTIC CENTER
Complete Chiropractic and Massage Care

6314 FM 2100 Crosby, TX 77532
P: (281) 462-2500 F: (281) 215-5099
www.BalanceChiropractic.biz
ChiropracticWithMassage@gmail.com

Patient Information

Name ______________________ Date ____________
Preferred Name ______________________________
Address ____________________________________
City________________ State__________ Zip__________
Birth Date______________ Patient SSN__________________
Sex__________ Age________ Marital Status______________
Employer____________________________________
Spouse's Name________________ Birth Date____________
Spouse's SSN ________________________________
Employer____________________________________

Phone Numbers

Home ______________________
Cell ______________________
Work______________________

Emergency Contact

Name ______________________
Relationship ________________
Phone ______________________
Alt phone ___________________

Health Insurance

1. Name of Insurance Company______________________
Primary Holder ______________________________
Birth Date________________ SSN __________________

2. Name of Insurance Company ______________________
Primary Holder ______________________________
Birth Date________________ SSN__________________

Email Address

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Primary Doctor Information

Physician Name________________
Phone Number ________________

Authorizations

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate.

The patient understands and agrees to allow this chiropractic office to use their PATIENT HEALTH INFORMATION for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PATIENT HEALTH INFORMATION is going to be used in their office and your rights concerning those records. If you would like to have more detailed account of our policies and procedures concerning the privacy of your PATIENT HEALTH INFORMATION we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

I hereby request and CONSET TO CHIROPRACTIC ADJUSTMENTS AND OTHER CHIROPRACTIC PROCEDURES, including various modes of physical techniques, on me (or the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above. Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am aware that as with all health care, there are some risks with treatment. Since not all factors of getting well are determined by the doctor, specific results cannot be guaranteed. By my (patient's or legal guardian's) signature, I acknowledge that I understand the risks of chiropractic treatment, and I choose to allow the doctors and staff associated with Balance Chiropractic Center, LLC. to treat me or the person for whom I am responsible.

Please note it is our office policy we close due to inclement weather in accordance with Crosby ISD.

X ________________________________ **Date** ________________
Patient/Guardian Signature

PATIENT CONDITIONS

Patient Name: ____ Date: __________________________

1. Area of pain ____________________________ Pain level 1-10 with 10 worse pain possible _________

Is the pain ☐ constant or ☐ comes and goes Is the pain getting worse? ☐ Yes ☐ No

Circle type of pain: Achy Burning Dull Numb Pinching Shooting Stabbing Stinging Tight Tingling Throbbing

2. Area of pain ____________________________ Pain level 1-10 with 10 worse pain possible _________

Is the pain ☐ constant or ☐ comes and goes Is the pain getting worse? ☐ Yes ☐ No

Circle type of pain: Achy Burning Dull Numb Pinching Shooting Stabbing Stinging Tight Tingling Throbbing

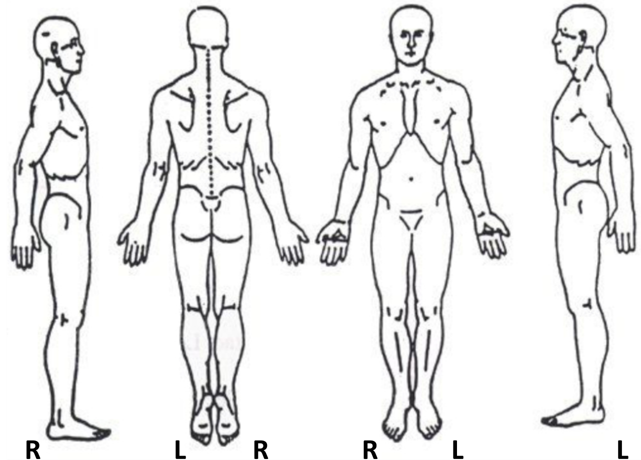
3. Area of pain ____________________________ Pain level 1-10 with 10 worse pain possible _________

Is the pain ☐ constant or ☐ comes and goes Is the pain getting worse? ☐ Yes ☐ No

Circle type of pain: Achy Burning Dull Numb Pinching Shooting Stabbing Stinging Tight Tingling Throbbing

Very clearly mark on the body chart (on the right) where you have pain, discomfort, numbness, or any other symptom/feeling that is out of the ordinary. Pay attention to the right and left sides of the body. Show any pain that travels from one area to the next.

Example: neck pain traveling down to the hand
(draw line from neck all the way to the hand)



What caused the pain? Unknown Fall Illness Motor Vehicle Collision Other ________________

When did the pain first start? *Approximate month & year* ______________________

What have you tried to help with the pain? Chiropractic? No Yes If yes, last adjustment __________________
approx. month & year

Over the counter medication? No Yes Prescription medication? No Yes Physical therapy? No Yes

Women only
Are you pregnant? No Yes If yes, expected date of delivery ________________________

List any medications you are taking for other health issues ____
____

Please indicate, describe & date if you have had any of the following: ****Write "NONE" if you have not****

Falls: ____ Head injuries: ___________________________________

Broken bones: ____

Dislocations: ____

Surgeries: ____

Patient Signature: _____________________________________
(Parent/Guardian)

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Review of Systems

Patient Name:

CONSTITUTIONAL
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain
- ☐ Weight loss

EYES
- ☐ Blindness
- ☐ Blurred vision
- ☐ Cataracts
- ☐ Change in vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Field cuts
- ☐ Glaucoma
- ☐ Sensitivity to light
- ☐ Tearing
- ☐ Wears glasses

CARDIOVASCULAR
- ☐ Angina
- ☐ Chest pain
- ☐ Claudication
- ☐ Heart murmur
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling of legs
- ☐ Varicose veins

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Difficulty breathing
- ☐ Difficulty sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum production
- ☐ Wheezing

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Neck pain
- ☐ Decreased motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Locking joints
- ☐ Back pain
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Muscle twitching
- ☐ Muscle weakness
- ☐ Swelling

INTEGUMENTARY
- ☐ Breast lumps/pain
- ☐ Change in nail texture
- ☐ Change in skin color
- ☐ Eczema
- ☐ Hair growth
- ☐ Hair loss
- ☐ History of skin disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin lesions

ENMT
- ☐ Bad breath
- ☐ Dentures
- ☐ Deviated septum
- ☐ Difficulty swallowing
- ☐ Discharge
- ☐ Dry mouth
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Frequent sore throat
- ☐ Head injury
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Post nasal drip
- ☐ Sinus infections
- ☐ Runny nose
- ☐ Snoring
- ☐ Sore throat
- ☐ Ringing in ears
- ☐ TMJ problems
- ☐ Ulcers

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Belching
- ☐ Black/tarry stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Abnormal stool caliber
- ☐ Abnormal stool color
- ☐ Abnormal stool consistency
- ☐ Vomiting
- ☐ Vomiting blood

GENITOURINARY
- ☐ Birth control therapy
- ☐ Burning urination
- ☐ Cramps
- ☐ Erectile dysfunction
- ☐ Frequent urination
- ☐ Hesitancy/dribbling
- ☐ Hormone therapy
- ☐ Irregular menstruation
- ☐ Lack of bladder control
- ☐ Prostate problems
- ☐ Urine retention
- ☐ Vaginal bleeding
- ☐ Vaginal discharge

NEUROLOGICAL
- ☐ Change in concentration
- ☐ Change in memory
- ☐ Dizziness
- ☐ Headaches
- ☐ Imbalance
- ☐ Loss of conscience
- ☐ Loss of memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep disturbance
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

PSYCHIATRIC
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite changes
- ☐ Behavioral changes
- ☐ Bipolar disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal indication
- ☐ Insomnia
- ☐ Location disorientation
- ☐ Memory loss
- ☐ Substance abuse
- ☐ Suicidal indication
- ☐ Time disorientation

ENDOCRINE
- ☐ Cold intolerance
- ☐ Diabetes
- ☐ Excessive appetite
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Goiter
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Unusual hair growth
- ☐ Voice changes

HEMATOLOGIC/LYMPHATIC
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood clotting
- ☐ Blood transfusions
- ☐ Bruise easily
- ☐ Lymph node swelling

ALLERGIC/IMMUNOLOGIC
- ☐ History of anaphylaxis
- ☐ Itchy eyes
- ☐ Sneezing
- ☐ Specific food intolerance
- ☐ COVID, date tested positive: ________________

☐ **Deny All**

Patient Signature: ______________________________ Date: ________________
(Guardian)