



Falite Chiropractic

The Brain Balance Place



Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____ - _____ - _____ Marital Status: M S D W

Occupation: _____ Employer: _____

Phone (home): _____ (work): _____

(cell): _____ email: _____

Spouse's Name & DOB: _____ Spouse's Employer: _____

Names & Ages of Children: _____

Hobbies: _____

Who referred you to our office: _____ Relationship: _____

Name of previous Chiropractor: _____ Last visit: _____

How long did you receive adjustments: _____ Why did you stop care: _____

Reason for consulting our office: _____

Past Trauma:

What accidents have you had? (i.e. car, bicycle, sports, slips/falls, etc.) Please include approximate dates: _____

What fractures or broken bones have you had? _____

Surgery/Illnesses:

What surgeries have you had? (i.e. C-section, heart bypass, hysterectomy, tonsillectomy, etc.) Please include approximate dates: _____

What major illnesses have you experienced? (i.e. pneumonia, cancer, TB, heart attack, stroke, etc.):

Medication:

Present prescription drugs: _____

Past prescription drugs: _____

Over-the-counter drugs (i.e. aspirin, antihistamines, laxatives, etc.): _____

Your Birth Record:

Birth place: Home / Birth Center / Hospital

Type: Vaginal / C-section

Procedures: Forceps / Vacuum Extraction

Any complications: _____

Current Health:

How would you describe your current health? _____

Do you use any of the following? tobacco / alcohol / coffee / cola / milk / artificial sweeteners

Level of stress: mild / moderate / severe

Do you use any of the following? purified water / vitamins / health foods / organic foods

Financial Information:

Are you planning on using some type of insurance? Yes / No

***If you are planning on using insurance, please provide our office with your policy information.

What method of payment will you be using? cash / check / credit card

By signing below, I understand that I am ultimately responsible for the payment of the balance due for my care in this office.

Patient's signature (or person responsible for account): _____

Please check any of the following symptoms you have had or are having now:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches / migraines | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Neck pain/tightness | <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Shoulder / arm / hand pain | <input type="checkbox"/> Loss of smell / taste | <input type="checkbox"/> Stomach pain / indigestion |
| <input type="checkbox"/> Grinding in neck | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Gall bladder problems |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Irritability / nervousness | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Allergies / hayfever | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Facial twitch | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Dizziness / fainting | <input type="checkbox"/> Jaw pain (TMJ) | <input type="checkbox"/> Arthritis / swollen joints |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bed wetting as child |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hip / knee / leg pain |
| <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Anemia | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Heart attack / stroke | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other: _____ | |

We look forward to helping you!!!