



3901 South Providence Ste. C
Columbia, MO 65203
Phone (573) 442-5520
Fax (573) 442-5524
www.achievebalancechiropractic.com

NEW PATIENT—outline of procedures for care and office policies.

To our new practice member, thank you for trusting us with your health care concerns. We are glad you are here and promise to do our best for you. We have outlined what you can expect in our office because we want you to feel comfortable here. Please read below and verify that you have done so by signing below. Then fill out the required paperwork and bring it to the desk when you are finished.

1st Visit:

All new patients are requested to fill out this personal health history questionnaire.

A one-on-one consultation will be done to discuss your health problems and to determine what may be the cause.

A specific scientific chiropractic examination is given. This includes those tests necessary to determine the precise cause of your problem.

The doctor will advise you if specific chiropractic postural x-rays are needed.

Payment for the first visit is required at time of service.

2nd Visit:

You will be **required** to attend your Doctor's Report at which time you will learn about health and healing from the inside out, what is looked at when reviewing your chiropractic x-rays, and what is involved in your complete chiropractic care plan. We request that you bring your spouse or loved one because at the end of the Report the direct cause of your problem will be discussed. This discussion includes a thorough explanation of your recommended complete corrective care plan and what results can be obtained. You will also be advised concerning how our office procedures work.

If you are accepted as a patient, your corrective care plan will begin. Additional explanation will be given on the different types of techniques that are available in the office.

After maximum correction has been obtained, a schedule of wellness care will be recommended to help prevent future problems and maintain good health.

Please circle the time you would like to be rescheduled for your 2nd visit:

Monday 5:30 pm Thursday 1:00 pm

Signature: _____

Date: _____

Welcome To Achieve Balance Chiropractic

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age _____ Today's date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home # () _____ Work # () _____ Ext. _____ Soc. Sec. # _____ - _____ - _____
 Fax # () _____ Cellular # () _____ E-mail Address _____
 ___ Male ___ Female # of Children _____ Single Married Significant Other Widowed Separated Divorced
 Your occupation _____ Employer _____ **WOMEN ONLY: Are you pregnant? No ___ Yes ___**
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
 Referred by? _____ Insurance: _____

Your Health Profile

***FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)

- | | | | |
|--|------------------------------|------------------------------|---------------------------|
| ___ Numbness/Tingling/Pain in (Arms / hands/ fingers)
R / L Both | ___ Hip Pain R / L | ___ Neck Stiffness/ Pain | ___ Back Stiffness/Pain |
| ___ Headaches/Migraines | ___ Arthritis | ___ Frequent Colds / Flu | ___ Diabetes |
| ___ Fractured Bones | ___ Convulsions/Epilepsy | ___ Skin Problems | ___ Asthma/Emphysema |
| ___ Swollen Painful Joints | ___ Tremors | ___ Blurred Vision R / L | ___ Double Vision R / L |
| ___ Anemia | ___ Chest Pain | ___ Lung Problems | ___ Loss of Taste |
| ___ Pain w/ Cough / Sneeze | ___ Stroke/Cerebral Vascular | ___ Gall Bladder Problems | ___ Digestive Problems |
| ___ Heart Problems | ___ Kidney Trouble | ___ Loss of Smell | ___ Loss of Balance |
| ___ Prostate Problems | ___ Buzzing/Ringing in ears | ___ Sinus Problems | ___ Nervousness/Anxiety |
| ___ Dizziness/Vertigo | ___ Depression | ___ Irritability/Mood Swings | ___ Tension/Stress |
| ___ Fatigue | ___ Sleeping Problems | ___ Cold Hands | ___ Stomach Upset |
| ___ Colon Trouble | ___ Bed Wetting | ___ Recurring Infection | ___ Diarrhea/Constip./Gas |
| ___ Cold feet | ___ Shortness of Breath | ___ Hot Flashes | ___ Jaw/TMJ Problems |
| ___ Foot Problems | ___ Light Bothers Eyes | ___ Problems Urinating | ___ Heartburn/Reflux |
| ___ Cold Sweats | ___ PMS | ___ Menopause | ___ Ulcers |
| ___ High Blood pressure | ___ Thyroid Problems | ___ Allergies | ___ Cancer (Type) _____ |
| ___ Other _____ | ___ Osteoarthritis | | |

Additional Explanation: _____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____
 What were the results of your previous care? _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No
 Was this due to an accident/Trauma? Yes No
 If Yes, explain.(ex. fall, auto, sports,)

Symptoms: When this problem is at it's worst, can you explain in your words how exactly it feels? _____

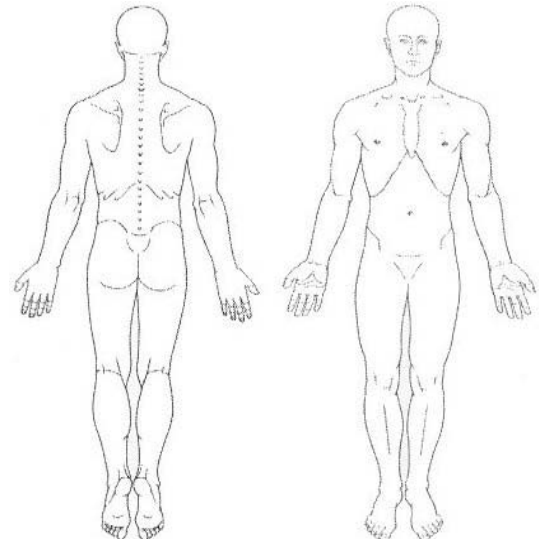
Severity Mild Moderate Severe
 On a scale of 0-10 with 10 being the worst and 0 being no pain, rate how you feel today (circle #)
 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Does this pain travel or radiate? If so, Where? _____

Quality: (mark all that apply)

- | | | | |
|----------------------------------|-----------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Diffuse | <input type="checkbox"/> Dull/Aching | <input type="checkbox"/> Localized |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling |

Please mark on the diagram below the area of discomfort. ↓



Patient Name: _____

Date: _____

Timing:

- Worse AM Worse PM Worse W/ Activity Worse Sleeping
- Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

How often do you find yourself suffering from this problem? _____

How long does the problem last? (all the details of timing) _____

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Changing Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please List any effects that this may have on any Recreational Activities: _____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions?

Is there anything else you think the doctor should know concerning your condition? Yes _____ No _____

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

Signature

____/____/____
Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

Consent to evaluate and treat a minor:

I, _____ being the parent or legal guarding of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Signature)

(Date)



3901 S. Providence Ste. C
 Columbia, MO 65203
 Phone (573) 442-5520
 Fax (573) 442-5524
 achievebalancechiropractic.com

FAMILY HEALTH HISTORY

Condition	Self	Father	Mother	Spouse	Children	Siblings	Grandchildren
Allergies							
Arthritis							
Asthma							
Attention Deficit							
Back Trouble							
Bed Wetting							
Cancer							
Carpal Tunnel							
Diabetes							
Digestive Problems							
Disc Problems							
Ear Infections							
Ear/Nose/Throat							
Emotional Problems							
Fibromyalgia							
Headaches							
Heart Trouble							
High Blood Pressure							
Hip Pain							
Immune Disorders							
Leg Pain							
Migraines							
Neck Pain							
Nervousness							
Pinched Nerve							
Currently Pregnant							
Sciatica							
Scoliosis							
Seizures							
Shoulder Pain							
Sinus Trouble							
Sports Activities							
Stress							
TMJ							
Deceased							
Other:							

Reviewed by Doctor _____ Date _____