Name:_____

Your thoughts are critical to our success in helping you.

At Balance Wellness Center we have seen too many people in our community give up on their health goals and life aspirations. We passionately provide a quantitatively based system that allows you to create a positive transformation in your health and life. The goal for our practice members is to co-create strategies for achieving their optimal health, and connect to a like minded community committed to an extraordinary life.

Your nervous system is the master system and controller of your body. Health and wellness are mediated through your nervous system. What makes our office specialized is that we have a proactive approach to supporting and expanding your health by improving how your nervous system functions. The NeuroSpinal Function Index (NSFi), which is the rating of results of the series of tests with the NASA Space Institute certified technology that your doctor will perform on you, scales from 0-100. The higher the score, the better your NSFi and ultimately the healthier you typically are, and the faster you can heal.

Lifestyle stress adversely effects your nervous system and general health. Many times, when people think they have a 'back problem', what they really have is a health problem' that is a result of the way they are living.

Please answer the following questions so we may better understand how to help you:

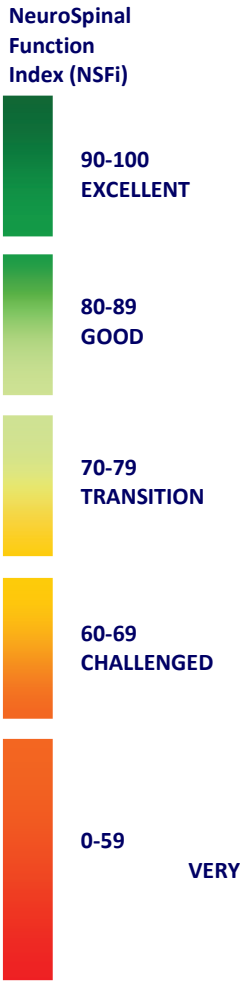
1. On a scale of 1 to 10 (10 being the most important) how important is correcting your health problems to you?_____

On the graph to the right:

1. Please put an 'X' to score where you think you are today.
2. Please Circle where you would like to be (your goal).
3. How long do you think it might take to get to where you circled?____
4. What things might you need to change to help you reach your goal?
5. What things might you need to change to help you reach your goal?

   a. _____
   b. _____
   c. _____
   d. _____

6. If we could make recommendations that would not only address your main concerns, but could also help you with improving your overall health, would you like to hear them? _____ yes _____ no



Please check reason(s) for pursuing chiropractic care:

____ I'm continuing ongoing care from another chiropractor.
____ I'm interested in wellness and natural health care.
____ General health and maximized function of my body.
____ I'm concerned about my health and I'm looking for answers.
____ I want to improve my immune function.
____ I have no idea why I'm here :). Please take the time to explain to me what you do
____ I have a specific condition that concerns me.

808 Village Center Dr.
Colorado Springs, CO 80919
(719) 265-0115

NAME: AGE: DOB: / / DATE:

ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE# CELL#

E-MAIL ADDRESS:

MALE: FEMALE: HEIGHT: WEIGHT: BLOOD PRESSURE:

OCCUPATION: EMPLOYERS NAME AND PHONE #:

SINGLE: MARRIED: **SPOUSES NAME:** DIVORCED: WIDOWED:

NO OF CHILDREN: NAMES, AGES AND GENDER:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Your Health Profile

Why This Form Is Important

At Balance Wellness & Chiropractic Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Addressing what brought you to this office

Please briefly describe your chief concern, including the effect it has had on your life.

	Health Concerns: *List health concerns according to their severity.*	Rate of Severity 1= mild 10= extreme	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or Intermittent?
1						
2						
3						
4						

If you are experiencing pain, is it… Sharp Dull ache

Does the pain travel/radiate anywhere: no yes - please describe for each condition.

Since the problem started, it is… About the same Getting Better Getting Worse

What makes it worse? _____

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

_____

Do you have a family history of this or similar symptoms Yes No (if yes, please explain) _____

_____

Is this condition interfering with your: Work Leisure Sleep Sports/exercise/walking, Positive mental attitude Hobbies Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? Yes No(i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what? _____

Please list other Doctors seen for this condition: Chiropractor Medical Dr. Other _____

1. Name/Address: _____

Date: What was the diagnosis?

What was done?

2. Name/Address:

Date: What was the diagnosis?

What was done?

General History:

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches	Ringing in ears	Sleeping problems	Urinary Problem
Pins and needles in legs	Nervousness	Stiff Neck	Heartburn
Fainting	Numbness in fingers	Cold Hands	Mood Swings
Neck pain	Numbness in toes	Cold Feet	Menstrual Pain
Pins & needles in arms	Loss of taste	Diarrhea	Menstrual Irregularity
Loss of smell	Stomach Upset	Constipation	Ulcers
Back Pain	Fatigue	Fever	
Loss of balance	Depression	Hot Flashes	
Dizziness	Irritability	Cold Sweats	
Buzzing in ears	Tension	Lights bother eyes	

Other conditions/diseases you would like the doctor to be informed of: _____

List any medications you are taking and why: (**prescription** and **non-prescription**) _____

_____

Have you had any surgery? (Please include all surgery)

1. Type Date Doctor

2. Type Date Doctor

3. Type Date Doctor

4. Type Date Doctor

Accidents and/or injuries: auto, work related or other (especially those related to your present problems).

1. Type: Date: Hospitalized Yes No How long:

2. Type: Date: Hospitalized Yes No How long:

3. Type: Date: Hospitalized Yes No How long:

Have you ever had x-rays taken? (If yes) When: _____ where: _____Area of body: _____

Do you wear orthotics or heel lifts? No Yes what size? _____For how long? _____

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
a._____
b. _____
c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, work chemicals, mold etc.)
a. _____
b. _____
c. _____

3. Psychological stress (work, relationships, finances, self-esteem, family issues, etc.)
a. _____
b. _____
c. _____

Your Ideal Health (Please fill this out, as it incredibly helps us serve your health and wellness care needs better)

What does it mean to you to be healthy? _____

_____

_____

Why is it important to you to achieve your ideal health? _____

_____

_____

If you had ideal health, what would that look like? _____

_____

_____

_____

What specific action steps do you feel you would need to start doing to achieve your ideal health?

_____

_____

_____

Adult-(18 to present)

Do you smoke? Yes How long _____ No Quit_____ years ago

Do you drink alcohol Yes No If yes how often? _____ How much? _____

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none/ 10=extreme)
Occupational:

Personal:

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: Exercise habits: Sleep:

General Health: Mind-set: Commitment to your health:

Commitment to correcting your health problems:

Family History

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health conditions or concerns they may have:
Children: _____
Spouse: _____
Mother: _____
Father: _____

Would you be interested in a complete life development system that could help you create an extraordinary life in 12 interconnected categories? Yes No

Have you watched the Reggie Gold (Muttonchops) video off of our website? Yes No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ **Date:** _____

Today's visit
Today's visit will involve collection of information to determine if and where a subluxation(s) exists in your body. All tests and x-rays must be thoroughly examined therefore treatment may not begin until the second visit. If additional testing or films are necessary, they will be performed on the second visit. Please schedule your second visit, "Doctor's Report of Findings" with the front desk assistant.