



Back To Balance Wellness Centers

Midtown Location:
1280 West Peachtree Street, Suite 250
Atlanta, GA 30309

Alpharetta Location:
131 Roswell Street, Cottage B, Lower Level
Alpharetta, GA 30009

New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data			
First Name	Last Name	Date	Email*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.			

Mailing address			
Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone (Cell)	(Work)	Referred By	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Age	Birth Date	Social Security #	Number of Children
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Occupation	Employer		
<input type="text"/>	<input type="text"/>		
Marital Status	Spouse's Name	Spouse's Occupation	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Spouse's Employer	Spouse's Health Status		
<input type="text"/>	<input type="text"/>		
Emergency Contact	Phone		
<input type="text"/>	<input type="text"/>		
Preferred Method of Contact: (Circle One) Text Cell Work Email			

Current Complaints	
Nature of Injury: (circle one)	Automobile Work Sports Other
Please describe:	<input type="text"/>
Date if Injury	Date symptoms appeared
<input type="text"/>	<input type="text"/>
Have you ever had same condition?	<input type="radio"/> No <input type="radio"/> Yes If yes, when?
<input type="text"/>	<input type="text"/>
List of other practitioners seen for this injury/condition	<input type="text"/>
Have you ever been under chiropractic care?	<input type="radio"/> No <input type="radio"/> Yes
If yes, please describe	<input type="text"/>

Insurance Information	
Name of party responsible for payment	Phone
<input type="text"/>	<input type="text"/>
Do you have health insurance?	<input type="radio"/> No <input type="radio"/> Yes Name of company
<input type="text"/>	<input type="text"/>
* If an auto accident, please provide:	
Insurance Company Name	Contact Person
<input type="text"/>	<input type="text"/>
Phone:	Claim #
<input type="text"/>	<input type="text"/>

Signatures	
Name of the insured	_____
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.	
Patient's signature	Date
<input type="text"/>	<input type="text"/>
Spouse's or guardian's signature	Date
<input type="text"/>	<input type="text"/>

Medical History

Have you been treated for any conditions in the last year? No Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? No Yes

Have you had X-rays taken? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc.)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Had surgery?	<input type="radio"/>	<input type="radio"/>	<input type="text"/>

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Do you take vitamin supplements?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please Tell Us A Little More About Yourself...

Current Vitals:

Height: _____ Weight: _____ Age: _____ Sex: _____

Vascular Risk Questions:

- Have you ever suffered a stroke? No Yes
- Has anyone in your family ever suffered a stroke? No Yes Who/Age? _____
- Have you ever suffered a heart attack? No Yes
- Has anyone in your family ever suffered a heart attack? No Yes Who/Age? _____
- Do you have any known vascular disease? No Yes
- Does anyone in your family have any vascular disease? No Yes Who/Age? _____
- Do you smoke? No Yes How much? _____
How long? _____
- Have you ever smoked in the past? No Yes When did you quit? _____
How long did you smoke
before you quit? _____
- Do you take birth control pills? No Yes When did you start? _____
- Have you ever taken birth control pills in the past? No Yes

Additional Information:

Please provide us with any additional Information that would be pertinent to your care:

Please use this space to expand on any previous area that you feel needs any additional explanation:

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

- A**=Ache **O**=Other
- B**=Burning **P**=Pins & Needles
- N**=Numbness **S**=Stabbing

