# Balance Health & Injury Clinic, PC

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Today's date:

## Basic Health Information/New Injury

Name: _____ DOB: _____ Gender: M F

Reason for visit: _____

When did your symptoms begin? _____

What caused them? _____

Since onset, have your symptoms been getting ❑ Better ❑ Worse ❑ No change

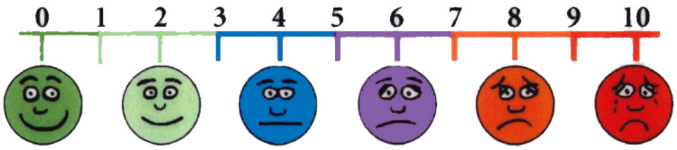
Other providers seen for this: _____

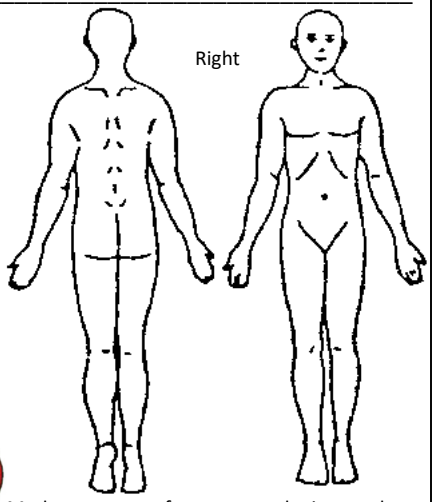
Does it interfere with your ❑ Sleep ❑ Work ❑ Daily Routine ❑ Recreation

What makes your symptoms better? _____

What makes you symptoms worse? _____

Please circle the number that corresponds to the severity of your symptoms.




Mark your areas of concern on the image above.

## Surgical History

List with year:

## Allergies or Reactions to Medication

## Current Medication/Supplements

Please list all medications or supplements with dose:

## Family Medical History

Please check ☑ for you and ☑ for family history.

| | | | |
|---|---|---|---|
| ❑❍ AIDs/HIV | ❑❍ Emphysema | ❑❍ Hepatitis | ❑❍ Obesity |
| ❑❍ Alcoholism | ❑❍ Epilepsy | ❑❍ Hyper/Hypo Thyroid | ❑❍ Osteoporosis/penia |
| ❑❍ Anemia | ❑❍ Goiter | ❑❍ Measles | ❑❍ Parasites |
| ❑❍ Arthritis | ❑❍ Gout | ❑❍ Mental Illness | ❑❍ Pneumonia |
| ❑❍ Cancer _____ | ❑❍ Heart Attack _____ | ❑❍ Multiple Sclerosis | ❑❍ Stroke _____ |
| ❑❍ Diabetes _____ | ❑❍ Heart Disease _____ | ❑❍ Mumps | ❑❍ Tuberculosis |

## Personal Health Information

**Health Habits**

Alcohol: _____glasses / day week month

Caffeine: _____glasses / day week month

Tobacco: _____packs / day week month

Stress: None Moderate Daily Heavy

Exercise: None Moderate Daily Heavy

**Work Activity**

❑ Sitting
❑ Standing
❑ Computer
❑ Light Labor
❑ Heavy Labor
❑ Hazards
❑ Repetitive

**Female Health**

Date of last menses: _____ ❑ Menopause
Age of first period: _____ ❑ PMS
Menses: ❑ Spotting ❑ Light ❑ Heavy
❑ Irregular ❑ Painful ❑ Clots ❑ Absent
Are you currently pregnant? ❑ Y ❑ N
Are you currently breast feeding? ❑ Y ❑ N
# of pregnancies: _____ # of live births: _____

## PERSONAL SIGNS AND SYMPTOMS

PLEASE CHECK ☑ FOR ALL THAT APPLY.

Provider Reviewed: ____ on ____

### *General*

I do not experience any of the following *general* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Bleed easily | ❑ Fatigue | ❑ Night sweats | ❑ Poor sleep | ❑ Swollen glands |
| ❑ Bruise easily | ❑ Fever | ❑ Peculiar tastes | ❑ Short temper | ❑ Vivid dreams |
| ❑ Chills | ❑ Lack of strength | ❑ Poor appetite | ❑ Sweat easily | ❑ Weight gain |
| ❑ Cold hands/feet | ❑ Muscle cramps | ❑ Poor circulation | ❑ Sudden energy drop | ❑ Weight loss |

### *Head, Ears, Eyes, Nose, and Throat (HEENT)*

I do not experience any of the following *HEENT* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Blurry vision | ❑ Ear aches | ❑ Excess saliva | ❑ Nasal congestion | ❑ Sinus pain |
| ❑ Concussion | ❑ Headache/migraine | ❑ Grinding teeth | ❑ Nose bleeds | ❑ Spots in eyes |
| ❑ Dizziness/vertigo | ❑ Thyroid issues | ❑ Itchy eyes | ❑ Red eyes | ❑ Sore throat |
| ❑ Dry throat/mouth | ❑ Eye pain/strain | ❑ Mouth sores | ❑ Ringing ears | ❑ Teeth/gum problems |

### *Respiratory*

I do not experience any of the following *respiratory* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Allergies | ❑ Cough | ❑ Frequent cold/flu | ❑ Pneumonia | ❑ Tight chest |
| ❑ Asthma | ❑ Coughing blood | ❑ Phlegm | ❑ Shortness of breath | ❑ Wheezing |

### *Cardiovascular*

I do not experience any of the following *cardiovascular* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Blood clots | ❑ Edema/swelling | ❑ Heart palpitations | ❑ Irregular heartbeat | ❑ Phlebitis |
| ❑ Chest pain | ❑ Fainting | ❑ High blood pressure | ❑ Low blood pressure | ❑ Tachycardia |

### *Gastrointestinal*

I do not experience any of the following *gastrointestinal* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Abdominal pain/ bloating | ❑ Blood in stool | ❑ Floating stools | ❑ Indigestion | ❑ Nausea |
| | ❑ Constipation | ❑ Gas/belching | ❑ Intestinal pain/ cramps | ❑ Odorous stools |
| ❑ Acid reflux | ❑ Dark stools | ❑ Hemorrhoids | | ❑ Rectal pain |
| ❑ Bad breath | ❑ Diarrhea | ❑ Hiccups | ❑ Mucous in stools | ❑ Vomiting |

### *Musculoskeletal*

I do not experience any of the following *musculoskeletal* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Low back pain | ❑ Redness/heat | ❑ Limited range | ❑ Rib pain | ❑ Moving pain |
| ❑ Neck/shoulder pain | ❑ Swelling | ❑ Limited use | ❑ Dull/achy pain | ❑ Stabbing pain |
| ❑ Upper back pain | ❑ Joint pain | ❑ Muscle pain | ❑ Fixed pain | ❑ Throbbing/burning |

### *Skin and Hair*

I do not experience any of the following *skin and hair* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Acne | ❑ Dry/brittle nails | ❑ Eczema | ❑ Loss of hair | ❑ Rash/hives |
| ❑ Dandruff | ❑ Dry skin | ❑ Fungal infection | ❑ Psoriasis | ❑ Ulcerations |

### *Neuropsychological*

I do not experience any of the following *neuropsychological* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Abuse survivor | ❑ Considered or attempted suicide | ❑ Easily stressed | ❑ Poor memory | ❑ Sudden weakness |
| ❑ Anxiety | | ❑ Irritable | ❑ Seeing a therapist | ❑ Tics |
| ❑ Confusion | ❑ Depression | ❑ Numbness | ❑ Seizures | ❑ Tingling |

### *Genitourinary*

I do not experience any of the following *genitourinary* items below ❑

| | | | | |
|---|---|---|---|---|
| ❑ Bedwetting | ❑ Dribbling urine | ❑ Incomplete urine | ❑ Nocturnal emission | ❑ Premature ejaculate |
| ❑ Blood in urine | ❑ Frequent urination | ❑ Increased libido | ❑ Pain with urination | ❑ Urgent urination |
| ❑ Decreased libido | ❑ Impotence | ❑ Kidney stones | ❑ Painful erection | ❑ Wake to urinate |

## PATIENT SIGNATURE

I have completed this document to the best of my ability and understand that any omissions may impact the ability of my providers to make an appropriate diagnosis and/or treatment plan.

Signature of patient (or guardian) _____ Date _____