

**Personal Information**

Date: \_\_\_/\_\_\_/\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Initial: \_\_\_\_\_

How would you like us to address you? \_\_\_\_\_ (nickname, title, etc.)

How were you referred to our office? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ (we will not send you jokes or junk)

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Drivers Lic # \_\_\_\_\_ state \_\_\_\_\_

**Primary Insurance**

Insurance Company: \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_ Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Relationship \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

**Primary Care Physician:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Please fill out the following section if accident related:

**Auto Information:** Company: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Accident: \_\_\_/\_\_\_/\_\_\_

Adjuster's Name: \_\_\_\_\_ Policy: \_\_\_\_\_ Claim#: \_\_\_\_\_

**Attorney Information** (If Personal Injury Case):

Atty Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address \_\_\_\_\_

**Worker's Comp Information**

Date of Accident \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Date the accident was reported \_\_\_\_\_

To whom was the accident reported \_\_\_\_\_

Worker's Comp Insurance Carrier \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Adjuster's Name \_\_\_\_\_ Claim #: \_\_\_\_\_

**CONSENT TO TREAT:** I hereby authorize Balanced Health Chiropractic/ Dr. David Gobbie and their assistants to perform examinations, physical therapy, and / or noninvasive diagnostic testing (including X-rays), and any other treatment that is medically necessary to me today and throughout the course of my treatment plan.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD:** I, \_\_\_\_\_, hereby give my permission for Balanced Health Chiropractic to treat my minor child with examinations, physical therapy and any other noninvasive procedures that are medically necessary.

Parent /Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** By signing on the line below, I am indicating that I have been given a copy of the Health Insurance Accountability and Portability Act to read. I was also informed by Balanced Health Chiropractic that a copy of these privacy practices can be made available to me anytime.

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Witness: \_\_\_\_\_

**Scheduling Appointments:** Balanced Health Chiropractic understands that sometimes circumstances prevent our patient's from keeping their scheduled appointments. If you cannot keep your regularly scheduled appointment please notify our office 24 hours in advance so that others in need can take your appointment slot. Also, if you are running more than 15 minutes late for your scheduled appointment, please notify our office. Thank you.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Confidential Case History**

O - Occasional  
 F - Frequent  
 C - Constant

Please use the frequency above and check off any of the following symptoms that you have experienced in the past year. If the symptom does not pertain to you, leave it blank.

	<b>O F C</b>		<b>O F C</b>		<b>O F C</b>
Allergy	__ __ __	Belching/Gas	__ __ __	Hard arteries	__ __ __
Chills	__ __ __	Colitis	__ __ __	high bld pres	__ __ __
Convulsions	__ __ __	Colon Trouble	__ __ __	low bld pres	__ __ __
Dizziness	__ __ __	Constipation	__ __ __	heart pain	__ __ __
Fainting	__ __ __	Diarrhea	__ __ __	bad circulation	__ __ __
Fatigue	__ __ __	Digestion	__ __ __	fast heartbeat	__ __ __
Fever	__ __ __	Abdomen	__ __ __	slow heartbeat	__ __ __
Headache	__ __ __	Hunger	__ __ __	swollen ankles	__ __ __
Loss of Sleep	__ __ __	Gall Bladder	__ __ __		<b>O F C</b>
Weight Loss	__ __ __	Hemorrhoids	__ __ __	Chest Pain	__ __ __
Nervous	__ __ __	Intestine worm	__ __ __	chronic cough	__ __ __
Depressed	__ __ __	Jaundice	__ __ __	diff. breathing	__ __ __
Neuralgia	__ __ __	Liver trouble	__ __ __	spit up blood	__ __ __
Numbness	__ __ __	Nausea	__ __ __	spit up phlegm	__ __ __
Sweats	__ __ __	Stomach pain	__ __ __	wheezing	__ __ __
Tremors	__ __ __	poor appetite	__ __ __		<b>O F C</b>
	<b>O F C</b>	Vomitting	__ __ __	boils	__ __ __
Arthritis	__ __ __	Vomit blood	__ __ __	bruise easily	__ __ __
Bursitis	__ __ __		<b>O F C</b>	dryness	__ __ __
Foot trouble	__ __ __	Asthma	__ __ __	hives/allergy	__ __ __
Hernia	__ __ __	Colds	__ __ __	itching	__ __ __
Pain:		crossed eyes	__ __ __	skin rash	__ __ __
Low Back	__ __ __	Deafness	__ __ __	varicose veins	__ __ __
Neck	__ __ __	Dental Decay	__ __ __		<b>O F C</b>
Shoulders	__ __ __	Earache	__ __ __	bed wetting	__ __ __
Arms	__ __ __	Ear Discharge	__ __ __	blood in urine	__ __ __
Elbows	__ __ __	Ear Noises	__ __ __	freq. urination	__ __ __
Hands	__ __ __	Glands	__ __ __	kidney infect.	__ __ __
Hips	__ __ __	Thyroid	__ __ __	kidney stones	__ __ __
Legs	__ __ __	Eye Pain	__ __ __	urination pain	__ __ __
Knees	__ __ __	Failing Vision	__ __ __	prostate prob.	__ __ __
Feet	__ __ __	Far sighted	__ __ __		
Tailbone	__ __ __	Gum trouble	__ __ __	For women:	<b>O F C</b>
Poor Posture	__ __ __	Hay fever	__ __ __	Breast pain	__ __ __
Sciatica	__ __ __	Hoarseness	__ __ __	cramps	__ __ __
Spinal Curve	__ __ __	nasal block	__ __ __	heavy flow	__ __ __
Swollen Joints	__ __ __	Near sighted	yes no	hot flashes	__ __ __
		Nose bleeds	__ __ __	irregular cycle	__ __ __
		Sinus infection	__ __ __	menopausal	__ __ __
		Sore throat	__ __ __	discharge	__ __ __
		Tonsillitis	__ __ __	Pregnant	yes__ No__

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_

**Please circle the follow conditions you have or have had:**

Cancer	Cold sores	Goiter	Measles	Rheumatic fever	Epilepsy
Anemia	Diabetes	Gout	Miscarriage	Scarlet fever	Venereal disease
Appendicitis	pneumonia	heart disease	mult.sclerosis	stroke	Whooping cough
exzema	HIV/AIDS	mumps	tuberculosis	arthritis	Polio
emphysema	influenza	pleurisy	ulcers	fever blisters	arteriosclerosis

**Tell us about why you are here today:**

What is your **major** complaint? \_\_\_\_\_

When did it start? \_\_\_\_\_ How did it start? gradually \_\_\_ suddenly \_\_\_

Explain: \_\_\_\_\_

Have you ever had this same or a similar condition in the past? yes \_\_\_ no \_\_\_

What aggravates your condition? (ex: bending, lifting, etc.) \_\_\_\_\_

What brings relief? (ex: rest, ice, etc.) \_\_\_\_\_

How does it feel? (circle) sharp achy dull deep stabbing stinging burning numb tingling crawling

Does it radiate to any other part of your body? yes \_\_\_ no \_\_\_ If yes, where? \_\_\_\_\_

With 0 representing no pain at all and 10 representing severe pain, please rate your pain: \_\_\_\_\_

When is the pain at its worse? (upon waking, with movement, etc.) \_\_\_\_\_

What past injuries may have caused this condition? (ex: accident, falls, sports injuries, etc.) \_\_\_\_\_

What (if any) other doctors have you seen for this condition? \_\_\_\_\_

Briefly describe your occupational duties: \_\_\_\_\_

Have you ever fractured a bone? yes \_\_\_ no \_\_\_ If yes, which one and when? \_\_\_\_\_

List any past surgeries: \_\_\_\_\_

Family Health History (parents, siblings) if relevant: \_\_\_\_\_

Please list any medications you are presently taking (be sure to include over the counter medications and vitamins). \_\_\_\_\_

for additional symptoms/complaints please use a separate page (Please ask for separate page)

# SUBJECTIVE ANALYSIS

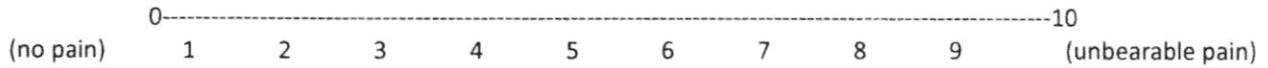
Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

(Initial: Re-exam)

## **VISUAL ANALOG SCALE**

(please indicate the pain level you are currently experiencing by writing each involved body area on the scale)



## **ACTIVITIES OF DAILY LIVING**

People with spinal pain may find that certain activities are restricted or difficult to do.

Circle all activities that you find difficult to do now:

- Sleep through the night
- Get out of bed
- Bathe yourself
- Wash, comb or dry hair
- Bend over sink for 10 minutes
- Go to the bathroom
- Put on socks, shoes or clothing
- Walk up one flight of stairs
- Walk down one flight stairs
- Crawl on all fours
- Turn a door knob
- Open a heavy door
- Sit in a chair for 30 minutes
- Sit and work at a desk for one hour
- Get up from a low seat
- Cross legs
- Walk one mile
- Stand for 30 minutes
- Travel on journeys that take over one hour
- Push or pull vacuum cleaner or lawn mower
- Carry laundry basket, groceries or a small child
- Wash windows or walls
- Bend over to clean bathtub
- Shovel snow or dirt
- Use, pencil, scissors, screwdriver or pliers
- Lift a heavy suitcase (about 40 pounds)
- Reach in front or overhead to high shelves
- Enjoy hobbies or social activities
- Enjoy sexual activities

Total #ADL items circled: \_\_\_\_\_

Circle any of the following conditions you are currently experiencing:

Subjective total: \_\_\_\_\_

- Neck or back weakness
- Restricted movement of neck or back
- Persistent tender areas in muscles around neck or back
- "Catch" or "kink" in neck

# PATIENT PAIN DRAWING

Name: \_\_\_\_\_ Date \_\_\_\_\_

## Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

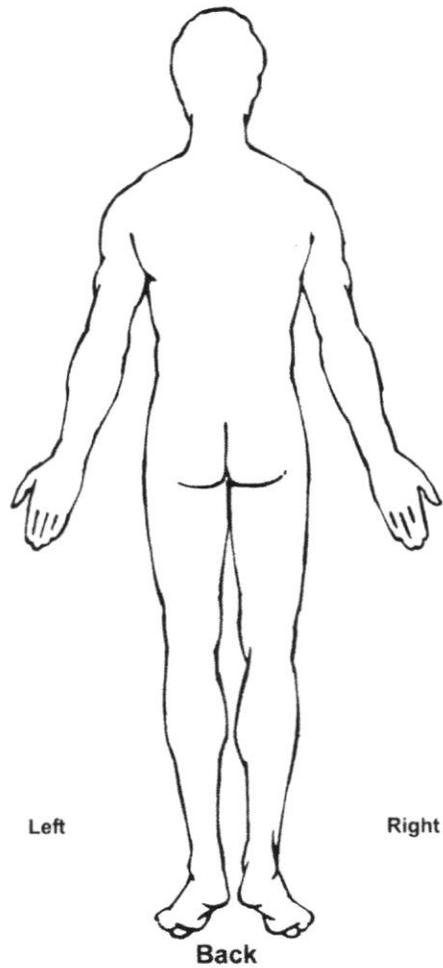
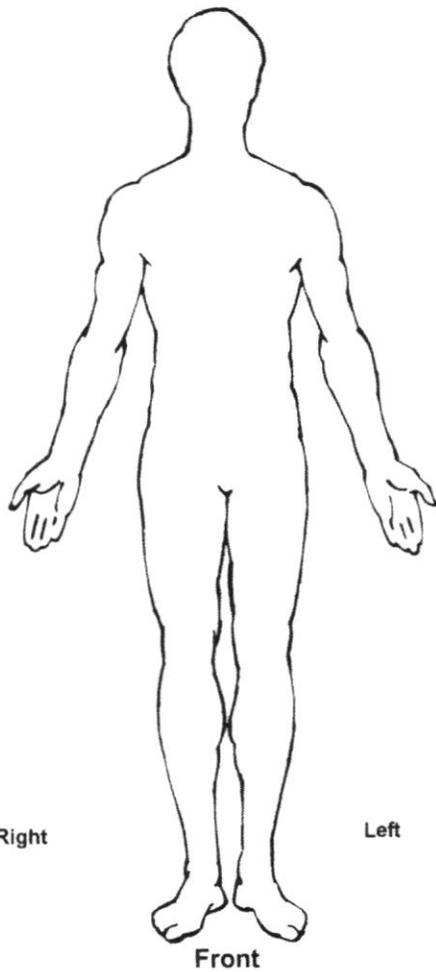
Aching  
▲▲▲

Numbness  
= = =

Pins and Needles  
○ ○ ○

Burning  
x x x

Stabbing  
/ / /



# Back Index

Form BI100

DOB:

rev 3/27/2003

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- Ⓐ The pain comes and goes and is very mild.
- Ⓛ The pain is mild and does not vary much.
- Ⓒ The pain comes and goes and is moderate.
- Ⓜ The pain is moderate and does not vary much.
- Ⓔ The pain comes and goes and is very severe.
- Ⓟ The pain is very severe and does not vary much.

## Personal Care

- Ⓐ I do not have to change my way of washing or dressing in order to avoid pain.
- Ⓛ I do not normally change my way of washing or dressing even though it causes some pain.
- Ⓒ Washing and dressing increases the pain but I manage not to change my way of doing it.
- Ⓜ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Ⓔ Because of the pain I am unable to do some washing and dressing without help.
- Ⓟ Because of the pain I am unable to do any washing and dressing without help.

## Sleeping

- Ⓐ I get no pain in bed.
- Ⓛ I get pain in bed but it does not prevent me from sleeping well.
- Ⓒ Because of pain my normal sleep is reduced by less than 25%.
- Ⓜ Because of pain my normal sleep is reduced by less than 50%.
- Ⓔ Because of pain my normal sleep is reduced by less than 75%.
- Ⓟ Pain prevents me from sleeping at all.

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓒ Pain prevents me from lifting heavy weights off the floor.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓔ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓟ I can only lift very light weights.

## Sitting

- Ⓐ I can sit in any chair as long as I like.
- Ⓛ I can only sit in my favorite chair as long as I like.
- Ⓒ Pain prevents me from sitting more than 1 hour.
- Ⓜ Pain prevents me from sitting more than 1/2 hour.
- Ⓔ Pain prevents me from sitting more than 10 minutes.
- Ⓟ I avoid sitting because it increases pain immediately.

## Traveling

- Ⓐ I get no pain while traveling.
- Ⓛ I get some pain while traveling but none of my usual forms of travel make it worse.
- Ⓒ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- Ⓜ I get extra pain while traveling which causes me to seek alternate forms of travel.
- Ⓔ Pain restricts all forms of travel except that done while lying down.
- Ⓟ Pain restricts all forms of travel.

## Standing

- Ⓐ I can stand as long as I want without pain.
- Ⓛ I have some pain while standing but it does not increase with time.
- Ⓒ I cannot stand for longer than 1 hour without increasing pain.
- Ⓜ I cannot stand for longer than 1/2 hour without increasing pain.
- Ⓔ I cannot stand for longer than 10 minutes without increasing pain.
- Ⓟ I avoid standing because it increases pain immediately.

## Social Life

- Ⓐ My social life is normal and gives me no extra pain.
- Ⓛ My social life is normal but increases the degree of pain.
- Ⓒ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- Ⓜ Pain has restricted my social life and I do not go out very often.
- Ⓔ Pain has restricted my social life to my home.
- Ⓟ I have hardly any social life because of the pain.

## Walking

- Ⓐ I have no pain while walking.
- Ⓛ I have some pain while walking but it doesn't increase with distance.
- Ⓒ I cannot walk more than 1 mile without increasing pain.
- Ⓜ I cannot walk more than 1/2 mile without increasing pain.
- Ⓔ I cannot walk more than 1/4 mile without increasing pain.
- Ⓟ I cannot walk at all without increasing pain.

## Changing degree of pain

- Ⓐ My pain is rapidly getting better.
- Ⓛ My pain fluctuates but overall is definitely getting better.
- Ⓒ My pain seems to be getting better but improvement is slow.
- Ⓜ My pain is neither getting better or worse.
- Ⓔ My pain is gradually worsening.
- Ⓟ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score

## NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

### SECTION 1 - PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

### SECTION 2 - PERSONAL CARE

- I can look after myself normally without causing extra pain.
- I can look after myself normally, but it causes extra pain.
- It is painful to look after myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self -care.
- I do not get dressed. I wash with difficulty and stay in bed.

### SECTION 3 - LIFTING

- I can lift heavy weights without causing extra pain.
- I can lift heavy weights, but it gives me extra pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

### SECTION 4 - WORK

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

### SECTION 5 - HEADACHES

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

### SECTION 6 - CONCENTRATION

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

### SECTION 7 - SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

### SECTION 8 - DRIVING

- I can drive my car without neck pain.
- I can drive as long as I want with slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.

### SECTION 9 - READING

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

### SECTION 10 - RECREATION

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

SCORE \_\_\_\_\_ [50]

BENCHMARK -5 = \_\_\_\_\_

## **Ideal Protein & Inflammation —Patient Interest Form:**

Helping You Take Control of Inflammation, Weight, and Wellness

Inflammation is a key contributor to many chronic conditions, including joint pain, fatigue, and difficulty losing weight. Research shows that excess weight, especially visceral fat, is directly linked to systemic inflammation in the body.

The Ideal Protein Protocol is a medically developed, structured ketogenic weight loss program designed to target inflammation at its source—by helping your body burn fat while preserving lean muscle. Many Ideal Protein participants report:

- \* Reduced Joint Pain**
- \*Increased Energy Levels**
- \*Improved Blood Markers (ei...Cholesterol, Blood Sugar)**
- \*Better Mobility and Decreased Stiffness**

We're proud to offer this protocol in our clinic as a natural complement to chiropractic care, supporting your overall healing and wellness.

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Would you like to learn more about how Ideal Protein could help you reduce inflammation and improve your health?

- Yes, I'm interested! Please follow up with me.**
- No, I am not interested in learning how to lose weight and get healthier**