



Two Worth Circle, Suite 3 Johnson City, TN 37601 • Phone (423) 262-0339  
www.BalancedHealingCenter.com

## Confidential Patient Application

Please invest a few moments to answer these questions so the Doctor can help you get better faster.

### PATIENT INFORMATION:

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

Sex: M or F Date of Birth: \_\_\_\_\_

Marital Status: S M D W Age: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_ - \_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

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

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

Work Phone: ( ) \_\_\_\_ - \_\_\_\_

Home Phone: ( ) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_ - \_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### SPOUSE INFORMATION:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

### ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

#### Reason for Consulting our office:

Relief of Symptoms

Correction of a Problem

Wellness care

List your health concerns in order of importance:

Health Concern	What have you tried to solve this concern?
1.	
2.	
3.	
4.	

Have you ever been to a Chiropractor? \_\_\_\_\_ If yes, how long ago? \_\_\_\_\_

If yes, what type of care did you receive?

Relief of Symptoms  Correction of a Problem  Wellness care

**How do you regularly care for your health?** (Circle All which apply)

- A. Vitamins/Minerals    B. Holistic Care    C. Exercise  
 D. Regular Medical    E. Good diet/nutrition    F. Chiropractic  
 G. Medication    H. Wait for Crisis    I. Other \_\_\_\_\_

**What have been the results of those choices?**

- A. Great results    B. Some Results    C. No Change  
 D. Worse    E. Still Trying    F. Other \_\_\_\_\_

**This health condition is beginning to affect my....?** (Or will affect)

- A. Job    B. Marriage    C. Time  
 D. Kids    E. Self esteem    F. Finances  
 G. Future abilities    H. Sleep    I. Not Applicable

On a scale of 1 to 10, with 1 being no commitment and 10 being total commitment, how committed to getting well are you?

- ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

**How have family/friends/co-workers been affected by your health condition?**

- A. No One notices    B. Unable to play with my kids normally  
 C. I'm told to do something    D. Unable to perform normal at work

What is this costing you? (Happiness, Sleep, Time, Money, Freedom, etc.)

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What are you most concerned about regarding this health problem?

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Where do you see yourself in 2 years if this problem isn't corrected?

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If you didn't have this problem, how would your life be better?

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What is your ultimate health goal in working with us?

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What is that worth to you?

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**Circle any of the following that are part of your health picture**  
(past or present):

Allergies	Fibromyalgia	Cerebral Palsy	Digestive Disorders
Cancer	Multiple Sclerosis	ALS	Sinus Trouble
Tuberculosis	Convulsions	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussion	Dizziness	Arthritis
Diabetes	Hepatitis	Infertility	HIV positive
Headaches	Fatigue	Sleeping problems	Cold Sweats
Mood swings	Loss of smell	Buzz/ring in Ears	Depression
Irritability	Problems urinating	Hot Flashes	Heartburn
Menstrual pain	Menstrual irregularity	Loss of Balance	Fainting

What is the name of your regular Medical Doctor? \_\_\_\_\_

May We Update your Medical Doctor with our Exam Findings? YES NO

Please Provide Your Doctors Clinic Name/Address Here:

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**CURRENT LIST OF SURGERIES, MEDICATIONS, AND HISTORY OF TRAUMA**

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List all operations and their date:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Medications currently taking: (if more than four please provide list)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

List any significant PHYSICAL traumas from birth to the present:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

List any significant EMOTIONAL traumas since birth:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**How stressful is your life?** (1 = No stress | 10 = Extreme stress)

Occupation      ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Personal         ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

What do you feel is your primary stress? \_\_\_\_\_

**FAMILY HEALTH PROFILE**

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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 mention below any health conditions or concerns you may have about your family:

Name	Age	Relation	Conditions

Do you have insurance?

YES NO

What is the name of your Insurance Company. \_\_\_\_\_

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, whether or not my insurance company contributes. I hereby authorize the doctors at the Balanced Healing Center and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practices of this office.

\_\_\_\_\_  
Patient's (Parent or Guardian's) Signature

\_\_\_\_\_  
Date

If you have insurance please provide your ID Card when you return this form to the receptionist. As a courtesy we will file your insurance for you.

**Thank you for completing all forms**

**We look forward to serving you!**