# Center For Creating Wellness

Dr. David Michael Balster, M.A., D.C.

## Patient Registration

***Fill these forms out completely and either bring them with you on your first visit.***

______________
***Date***

| | |
|---|---|
| ***Name*** | ***Social Security Number*** |
| ***Street Address*** | ***Drivers License Number*** |
| ***City*** ***State*** ***ZIP*** | ***Birth Date*** ***Age*** ***Sex*** |

| | | | |
|---|---|---|---|
| ***Home Phone*** | ***Work Phone*** | ***Cell Phone*** | ***Email Address*** |

***Employer*** ***Position***

***Employer's Address*** ***City*** ***State*** ***ZIP***

Single Married Divorced Widowed
***Marital Status (Circle One)***

__________________
***Number of Children***

***How did you find out about our office? (please circle all that apply)***

- ***Patient of this office***
- ***Friend***
- ***Co-Worker***
- ***Newspaper***
- ***Yellow Pages***
- ***Word of Mouth***
- ***Other*** _______________

***Who Referred You to Our Office:*** ______________________________

***What are you expectations of our office?*** __________________________________________

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***Past or Present Conditions***

*For past conditions, mark with an (O)*
*For present conditions, mark with an (X)*

**A)**
__Fractured Bones
__Auto Accidents
__ 0 -1 year ago
__1-5 years ago
__More than 5 yrs ago
__Other Accidents/Falls
__Knocked Unconscious
__Back Curvature
__Mental or Emotional
__Disorders
__Arthritis
__Diabetes
__Swollen or Painful Joints
__Convulsions/Epilepsy
__Skin Problems
__Itching
__Bruise Easily
__Cancer
__Frequent Colds/Flu

**B)**
__Nervous
__Tension
__Depressed
__Irritable
__Anemia
__Excess Sweating
__Tremors
__Light Bothers Eyes
__Allergy
__Sinus Problems
__Light Headed Upon Rising
__Under Stress
__Crave Sweets or Salts
__Eating Disorder

**C)**
__Trouble Sleeping
__Trouble Concentrating
__Loss of Memory
__Learning Disability
__Mistake Sidedness (R. from L.)
__Stutter
__Dyslexia
__Mood Changes
__Loss Temper Easily

**D)**
__Headache
__Neck Pain or stiff R./L.
__Numbness, tingling, or pain in arms, hands, fingers R.L.
__Jaw Pain or Click (T.M.J.) R.L.
__Head seems to heavy
__Head & Shoulders feel tired
__Difficulty in excessive (standing, walking, sitting, riding, bending, lifting, twisting, household duties)
__Should Pain R.L.
__Dizziness
__Ringing in ears R.L.
__Hearing Loss R.L.
__Fainting
__Loss of Balance
__Blurred or Double Vision R.L.
__Upper back pain or stiffness R.L.
__Mid back pain or stiffness R.L.
__Lower back pain or stiffness R.L.
__Numbness, tingling, or pain in buttocks, thighs, legs, feet, toes R.L.
__Pain with cough, sneeze or strain at stools
__Hip pain R.L.
__Foot trouble R.L.

**E)**
__Chest pain
__Asthma
__Lung problems
__Difficult breathing
__Wheezing
__Heart Problems
__Stroke
__High or low blood pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder trouble

**F)**
__Digestive problems
__Excessive Gas
__Belching/bloating after meals
__Heartburn
__Ulcers
__Diarrhea/constipation
__Colon Trouble
__Hemorrhoids
__Prostate problems
__Impotence

**G)**
__Kidney troubles
__Kidney stones
__Frequent urination
__Discharge
__Menstrual problems/PMS
__Menopausal problems
__Breast lumps, soreness, discharge
__Pregnant (now)
__Bedwetting
__Ear infections
__Hepatitis
__Venereal Disease
__HIV/AIDS
Other ________________
______________________
______________________
______________________
______________________
______________________
______________________
______________________
______________________

**309 East First Street** **(319) 465-4415**
**Monticello, IA 52310** **(800) 777-4415**

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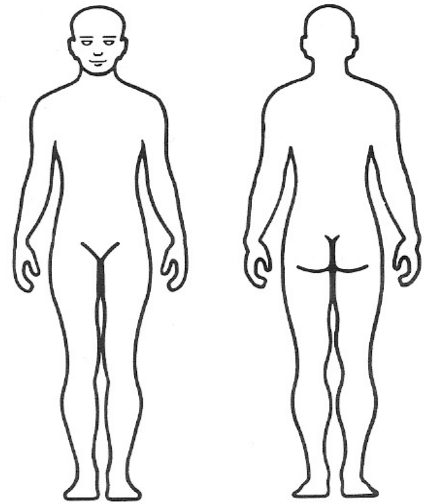
**On the diagram to your right, please indicate the areas of your pain. Then, mark the severity of your pain on the scale of 0 – 10.**




**Describe your major complaint:**

______________________________________
______________________________________
______________________________________
______________________________________
______________________________________
______________________________________

**How long have you had this condition:** _____________________________________________

**Date Began:** ________ **Have you lost work days: Yes / No** **How many?** _____

**Had you had this similar condition before? Yes / No** **When?** _______________________

**Is this an injury that is: Work related ( ) Auto Accident ( )**

**Is your pain:**

- **__ Worse in the morning and gets better as the day goes on**
- **__ Better in the morning and gets worse as the day goes on**
- **__ Same all day**
- **__ Made worse by heat OR __ Made better by heat**
- **__ Made worse by cold OR __ Made better by cold**

**Any radiation of pain into an extremity? Yes / No Explain:**__________________________

**Does any position relieve the pain?** _________________________________________________

**Frequency / duration of pain:** ______________________________________________________

**Name of other doctors seen for this condition, what was done, and for how long:**

________________________________________________________________________________
________________________________________________________________________________

**When did you last see a chiropractor:** _______________ **Dr. :** _________________________

**Why did you see this chiropractor?** _______________________ **Were you helped?** ________

**What health care programs were you given to follow to maximize wellness and balance in your life?** _______________________________________________________________________

**Did you follow them?** ________________ **If not, why?** __________________________________

**Why are you changing chiropractors?** _______________________________________________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**WHAT IS YOUR HEALTH PHILOSPHY?** (What should you do to be healthy?)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

___ Temporary Relief (Help the symptom but do not fix the cause of the problem)

___ Maximum Wellness (Address the cause of the problem for maximum stability & wellness)

**WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?** ______________________________________________

______________________________________________________________________

______________________________________________________________________

1. What are your favorite activities or hobbies to do now? ____________________________
2. Are your current problems affecting these activities or hobbies? ______________________
3. What activities are you looking forward to doing in retirement? ______________________
4. Who would you like to be doing these with? ____________________________________

**On a scale of 1 – 10 (1 being the least, 10 being the most, )**

___ How committed are you at being at your maximum health potential?

___ How important is it for your family to be at their maximum health potential?

___ How coachable are you?

___ How committed are you to a wellness program of care?

Have you had any surgeries? Yes / No If yes, please describe: ________________________

______________________________________________________________________

List any drugs you now take (prescription and non-prescription):

______________________________________________________________________

______________________________________________________________________

Are you currently wearing: __ Heel lifts __ Arch supports

Sleep position: __ Back __ Side __ Stomach

Anything else you think we should know about you, your past health history, or particular circumstances:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Please feel free to discuss our fees. Payment is due at the time of service.**

Signature: ______________________________ Date: _________

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