Balance Health & Injury Clinic, PC
1217 NE Burnside Rd, STE 301 ◆ Gresham, OR 97030 ◆ PH 503.492.2625

Date

Basic Health Information/New Injury

Name: _____ DOB: _____ Sex: M F

Reason for visit: _____

When did your symptoms begin? _____

What caused them? _____

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

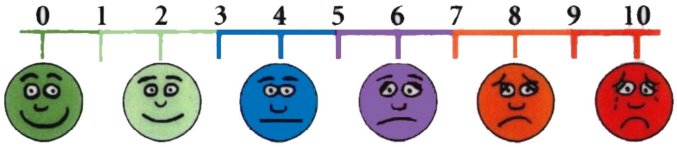
Other providers seen for this: _____

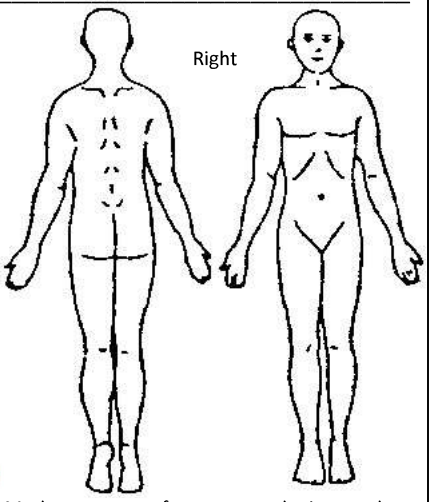
Does it interfere with your ❑ Sleep ❑ Work ❑ Daily Routine ❑ Recreation

What makes your symptoms better? _____

What makes your 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:

Please check ☑ for you and ⊘ for family history.

Medical History - Personal and Family

❑❍ 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: _____

Balance ◆ 1217 NE Burnside Rd, STE 301 ◆ Gresham, OR 97030 ◆ PH 503.492.2625 Reverse - New Injury/Complaint

Personal Signs and Symptoms

Please check ☑ for all that apply.

General

I do not experience any of the *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 *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 *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 *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 *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

Provider Reviewed: _____ on _____

Musculoskeletal

I do not experience any of the *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 *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 *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 *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.

Printed name of patient (or guardian)	Signature of same	Date