Health Report:

Reasons for seeking Care: _____

List any other providers seen for this: _____

List any diagnosis made and treatment received: _____

Have you had something similar to this before: _____

List the name of any family member with a similar problem: _____

Have you ever received chiropractic treatment previously? _____Yes _____No

If yes, explain: _____

Have you been treated for any health conditions in the last year:
_____

Are you currently taking medications? _____ Yes _____ No List Medications: _____
_____ What medications have you taken in the past, if any: _____
_____

List the conditions you are taking medications for: _____
Please list reasons and dates of any surgeries or hospitalizations _____
_____

Any previous broken bones or sprains/strains: _____

Family history of health conditions like: cancer, diabetes, arthritis, heart disease, stroke, or epilepsy: _____

Do you smoke Y/N. Alcohol Y/N, If yes how much: _____

Caffeinated drinks per day: _____ Do you take any vitamins or Supplements? If yes, the type and how often: _____
_____

Center of Balance
Dr. Juliet Tablak, D.C.

Name: _____

Date: _____

Address:

Zip:

City:

Phone#

Occupation:

Date of Birth:

Marital Status:

Name and Number of Person to Contact in Case of Emergency:

Referred By:

May we e-mail you with information about our office? Yes No
e-mail address_____ When, where and from whom did you last receive medical or health care?

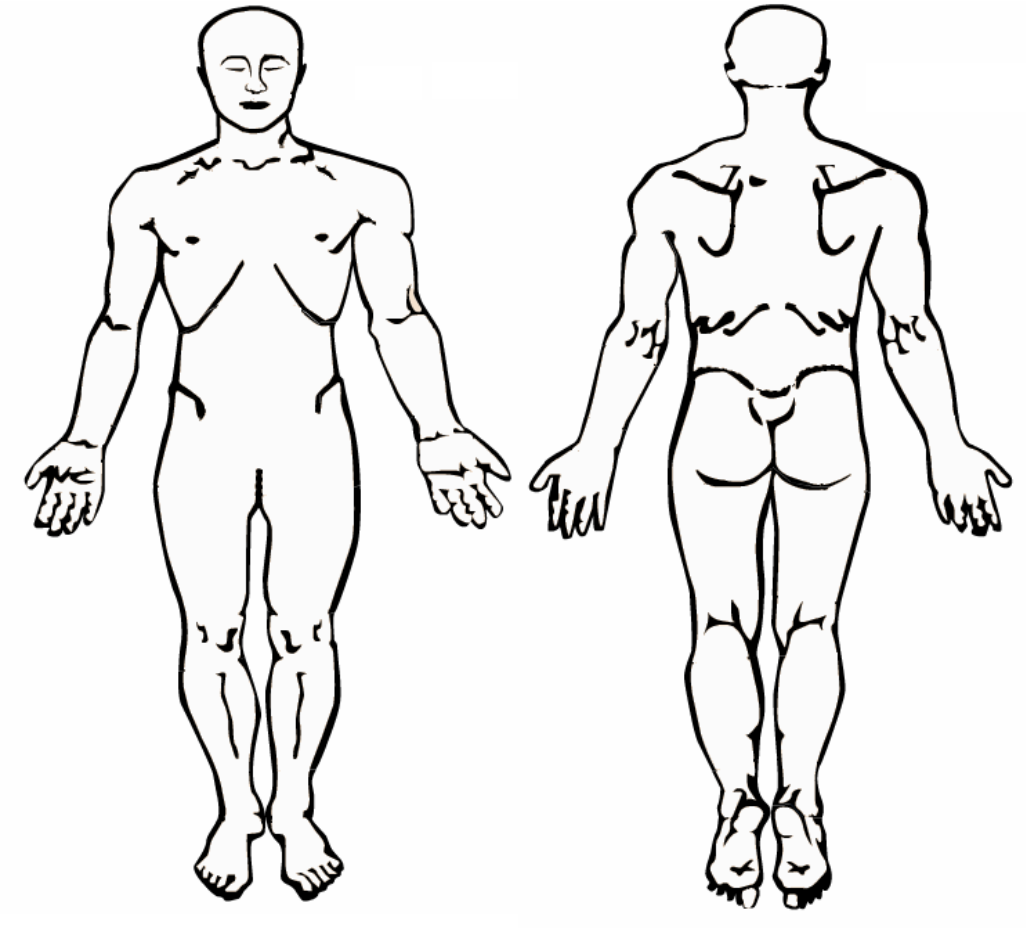
Age:

Marital status: S M W D (Please Circle)

Sex: Male/Female (please circle)

What are your most important health concerns? Please list from most to least important.
1.
2.
3.
4.
5.
6.
Others:
_____

Please indicate area of complaint on the picture.



Describe symptoms_____

What activities aggravate your condition: _____
_____

What activities lessen your condition: _____
_____

Is the condition worse at certain times? Y/N. When?_____
_____

Is the condition interfering with:
__Work __Sleep __Daily Life

Is the condition getting worse or better? _____

Is the condition due to injury at:__Work __Auto Accident __Personal Lifestyle Activities

Review of Symptoms

The following list of conditions may seem unrelated to your current health problem. However, these problems may influence your overall diagnosis, treatment plan and whether your case is accepted in this office.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diptheria
- ☐ Eczema
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fractures
- ☐ Headaches
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herniated Disk
- ☐ Influenza
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Mental Disorder
- ☐ Migraines
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Small Pox
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Whooping Cough

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST
CIRCLE ANY CURRENT HEALTH PROBLEMS

MUSCUO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Trouble
- ☐ Weight Gain/Loss
- ☐ Abdominal pain
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stools
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

CARDIO / RESPIRATORY

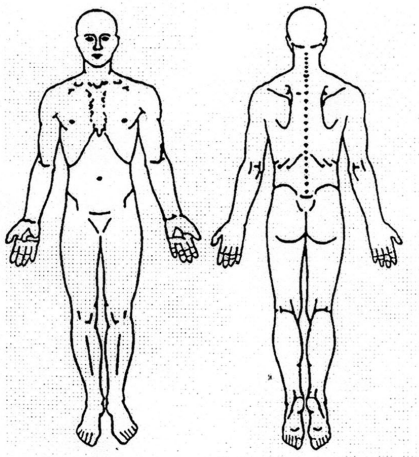
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes
- ☐ Currently Pregnant



Please outline on the diagram the area of your discomfort.

This information is true to the best of my knowledge:

Patient Signature X_____ Date:_____

Informed Consent & Office Policies

Our commitment here at Center of Balance and Juliet Tablak, D.C. is to serve our patients with professionalism

and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interest it may be necessary to share information with other Health care Providers or Associates for the purpose of ordering laboratory analysis, payment, scheduling of your appointment or in the instance of a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released with the written authorization of the individual, as provided for by law.
Please be aware Health and Safety Code section 109250 et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation or cure of cancer. If you have been diagnosed with cancer we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. All payment is expected at the time of service. Debit cards, master card, visa, cash and check are acceptable forms of payment. Payment is due at the time of service. If payment is not made within 30 days, your account will be charged a $25 monthly fee until payment is made.

Returned checks will be charged a $25 handling fee.

Please contact the office if you are having issue with payment for any reason. We will do our best to meet your specific needs.

Please be advised that if you cannot keep your scheduled procedure or appointment for any reason, we request that you cancel the appointment with at least 24 hours prior. Failure to cancel within that time frame or no showing for the appointment will be the cost of your appointment.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.
Sincerely,
Juliet Tablak, D.C. , Center of Balance

I have read and understand this form.
Signed: _____
Print Name: _____Date:_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic names below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

Print Patient's Name_____

Signature of Patient_____

Date Signed:_____

To be completed by patient's representative, if necessary, e.g. if patient is a minor or physically or legally incapacitate.

Print Name of Patient_____

Print Name of Patients Representative_____

Signature of Patients Representative As:_____

Relationship or Authority of Patients Representative_____

Date Signed:_____

Name of Doctor treating this patient: Juliet Tablak, D.C.