Balanced Body CHIROPRACTIC MN, P.A.

Dr. Jen Skelton, DC, CVSMT Phone # 952-807-5397 Fax: 952-452-8334
10740 Lyndale Ave S., Suite 18E, Bloomington, MN 55420
E-mail: drjen@balancedbodymn.com Website: www.balancedbodymn.com

Current complaint and Health History

Complaints

Primary Complaint?

_____

Secondary Complaint?

_____

When did your problem begin?

_____

How did your problem begin?

_____

Is this problem interfering with your: (circle all that apply)

Activities of daily living Work Social Activities Hobbies Sleep

Rate your pain: (Circle one) 0 being no pain and 10 being the worst pain

0 1 2 3 4 5 6 7 8 9 10

Is your health problem worse: (Circle all that apply) Morning Day Evening Night

Does your health problem occur: (Circle one)

Occasionally Intermittently Constantly Frequently

Is your problem getting: (Circle one) Better Worse Staying the Same

Have you had this problem before? _____ When? _____

What aggravates your health problem: (circle all that apply)

Coughing Sneezing Walking
Reaching Lifting Bending
Sitting Lying down Standing
Neck movement Straining at stool others _____

What relieves your health problem: (circle all that apply)

Nothing Resting Heat

Sitting Standing Ice Others _____

Have you had recent treatment for this condition? Yes No

Who did you see? _____ Treatment _____

Have you had any changes in bowel or bladder habits since your problem began? Yes No

List your hobbies:

1) _____

2) _____

3) _____

What are your habits?

Smoking	never	packs per day _____
Alcohol	never	drinks per day_____
Caffeinated Drinks	never	drinks per day_____
Exercise	never	times per week_____
Drug/Substance Abuse	never	Yes (if yes discuss with your doctor)

Medical History

Have you seen a doctor of chiropractic? Yes No

Who is your Family Physician:_____ Date of last physical exam:_____

Have you been hospitalized in the past five years? Yes No

Date and Reason: _____

Have you had any serious accidents in the past five years: Yes No

Date and Describe: _____

Have you had broken bones, dislocations, strain/sprains, injuries or falls in the past 5 years: Yes No

Date and Describe: _____

List your medications: _____

Review of Systems

General

- ☐ Fevers
- ☐ Fainting
- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Weight loss / Gain
- ☐ Sweats

Eyes/Ears/Nose/Throat

- ☐ Contacts / Glasses
- ☐ Eye pain
- ☐ Sinus infections/trouble
- ☐ Cataracts
- ☐ Ringing in the ears
- ☐ Sore throat
- ☐ Poor Vision
- ☐ Earache
- ☐ Hoarseness
- ☐ Dryness
- ☐ Hearing loss
- ☐ Redness
- ☐ Nosebleeds

Skin

- ☐ Dryness
- ☐ Rash / Hives
- ☐ Varicose veins
- ☐ Sensitive Skin
- ☐ Itching
- ☐ Jaundice (yellowing of the skin)
- ☐ Suspicious lesions

Musculoskeletal

- ☐ Weakness
- ☐ Spinal Curvature
- ☐ Pain between shoulder blades
- ☐ Joint swelling
- ☐ Neck pain / Stiffness
- ☐ Low back pain

Pain, Numbness or Tingling in:

- ☐ Shoulders
- ☐ Wrists / Hands
- ☐ Knees
- ☐ Arms
- ☐ Hips
- ☐ Ankles / Feet
- ☐ Elbows
- ☐ Legs

Cardiovascular

- ☐ High blood pressure
- ☐ Slow heart rate
- ☐ Poor circulation
- ☐ Low blood pressure
- ☐ Racing / skipping heart rate
- ☐ Chest pain/discomfort
- ☐ Palpations

Respiratory

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough

Gastrointestinal

- ☐ Acid reflux / Indigestion
- ☐ Change in appetite
- ☐ Abdominal pain
- ☐ Nausea / Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Gas

Genitourinary

- ☐ Frequent urination
- ☐ Bed wetting
- ☐ Incontinence
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Kidney trouble
- ☐ Kidney infections or stones
- ☐ Bladder Infections

Neurologic

- ☐ Headaches / Migraines
- ☐ Dizziness / Vertigo
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Concussions
- ☐ Difficulty with concentration

Endocrine

- ☐ Cold intolerance
- ☐ Heat intolerance

Heme / Lymphatic

- ☐ Abnormal bruising / Bruise easily
- ☐ Enlarged lymph nodes

Conditions

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer / Leukemia
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Gall Bladder problems
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart disease / trouble
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Liver Problems
- ☐ Pacemaker
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease / STD's

Women Only

- ☐ Irregular Cycles
- ☐ Excessively heavy periods
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Cramps / Backaches
- ☐ Breast changes
- ☐ Hot flashes
- ☐ Problems conceiving
- ☐ Are you currently pregnant?

Family History

Has anyone in your family had any of the following: (if yes list relationship to patient)

Cancer:_____ Diabetes:_____

Heart Trouble: _____ High Blood Pressure: _____

Do any family members suffer from the following: please circle and list the relationship to you

Neck Problems: _____

Back Problems: _____

Headaches: _____

Arthritis: _____

Disc Problems: _____

Bad Posture: _____

Scoliosis: _____

Osteoporosis: _____