A Balanced Approach Therapy Centre

'Healing Through Balance Through Therapy'

Name: _____ Birth Date_____ Date_____

Address:_____ _____
City Province Postal Code

Home Phone: (____)_____Work (____)_____Ext_____Cell (_____)_____

Best time and place to reach you_____

CONTACT IN CASE OF EMERGENCY: _____ Relationship_____

Home Phone: (____)_____Work (____)_____Ext_____Cell (_____)_____

Whom may we thank for referring you?_____

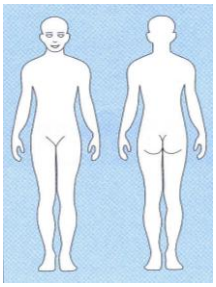
Would you like to receive our newsletter via email? Yes/no Email address: _____

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

*Mark an **X** on the picture where you continue to have pain, numbness, or tingling.*



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Activities or movements that are painful to perform □Sitting □Standing □Walking □Bending □Lying Down

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

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy
□ Chiropractic Services □ Massage Therapy □ None □ Other _____

Exercise: □ None □ Moderate □ Daily □ Heavy

Work Activity: □ Sitting □ Standing □ Light Labour □ Heavy Labour □ Mixed

Habits: □ Smoking Packs/day: _____ □ Alcohol Drinks/Week: _____
□ Coffee/Caffeine Cups/Day: _____ □ High Stress Level Reason_____

Injuries/Surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Surgeries		
Birth Trauma/Injury		

Do you have any pins or plates? _____ If yes, where? _____

Medication(s)	**Allergies**	**Vitamins/Herbs/Minerals**