INTAKE FORMS

Dr. Harrison and his team welcome you to The Balanced Atlas.

As a member of the National Upper Cervical Chiropractic Association, we are dedicated to the detection and correction of the Atlas subluxation. We honor life, health, and the healing process and believe that every man, woman and child should be checked from birth for nervous system interference and adjusted, when necessary, for life. **We treat every person who walks into our office just as we would want to be treated; with Love, Compassion, Understanding and Truth.** We provide the education and inspiration needed to help our community to make positive lifestyle changes and choices, so they can experience and maximize their optimal health, happiness and wellbeing. Professionally we grow, learn and refine our skills to give our practice members the best service possible regarding their most prized and precious resource, their health.

The Balanced Atlas provides NUCCA (National Upper Cervical Chiropractic Association) care to the families in the San Francisco Bay Area. NUCCA is an extremely gentle form of Chiropractic that requires no forceful twisting or popping of the neck or spine. The goal of NUCCA is to re-align the spine gently, allowing our patients to maintain their alignments for eventually months to years at a time. Whether you have "been everywhere" and have had no results, or you are looking for an even higher quality of life, The Balanced Atlas and NUCCA care are for you.

THE BALANCED ATLAS

EST. 2013

SAN FRANCISCO

THE BALANCED ATLAS
EST. 2013
SAN FRANCISCO

Tel: (415) 242-1472
Fax: (415) 242-1479
2121 19th Ave. Suite 100
San Francisco, CA 94116
E-mail: jes@thebalancedatlas.com
www.TheBalancedAtlas.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home and/or Cell phone:	**Work phone:**
Cell phone:	**Email address:**
Best number to contact you:	
Date of birth:	**Age:**
Name/Age of children:	**Pregnant?** Yes ☐ No ☐
Height:	**Weight:**
Driver's license number:	
Marital status: M S W D SEP ENG SIG.OTH	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	

Who/What may we thank for referring you? _____

Addressing What Brought You Into This Office:

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Other doctors you have seen for this condition:

Chiropractor	☐
Medical Doctor / Physical Therapy	☐
Acupuncture / Massage / Other Alternative Form of Treatment	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

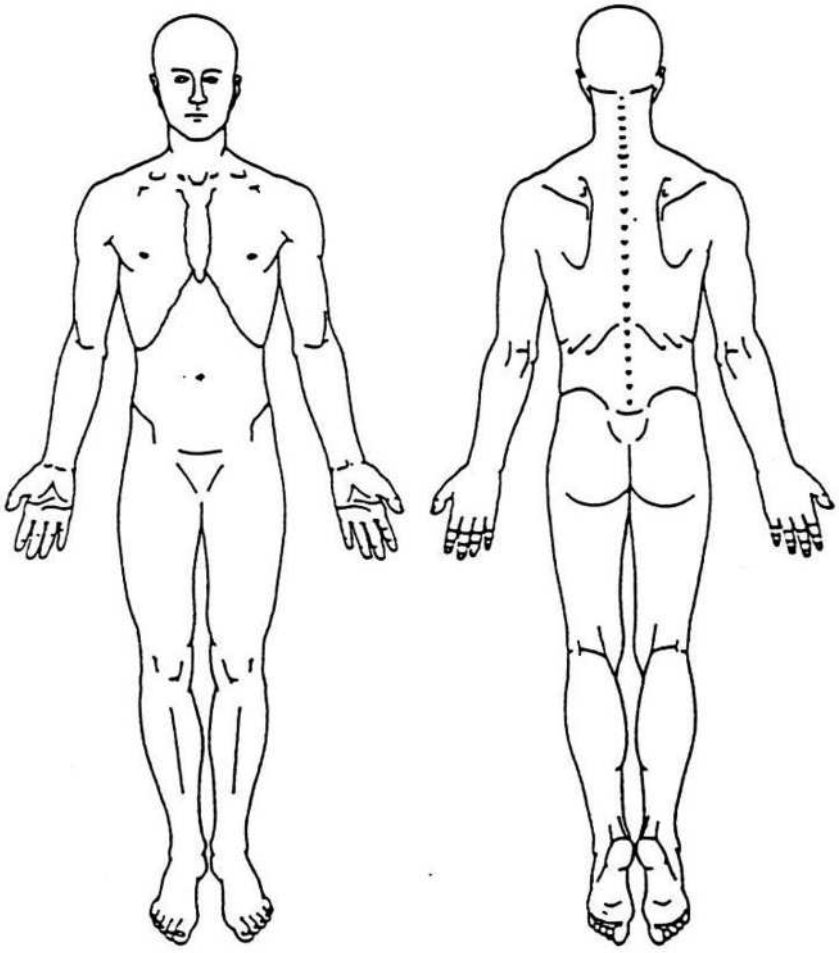
Is this condition interfering with any of the following:

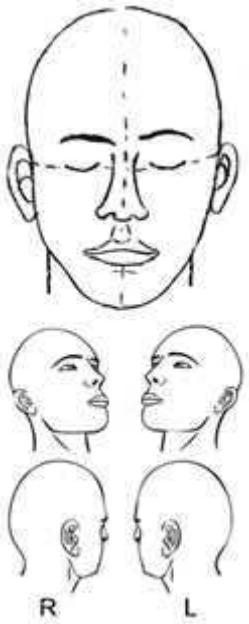
Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

Symptomatic Diagram

Using the letters below, mark the areas on your body where you feel the descriped sensations.

A=Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing





General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

_____

_____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Malaria	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Nervousness	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain) _____

_____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
   c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

On a scale of 1-10 (1 being low stress and 10 being very high stress) please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you which has not been discussed?

_____
_____
_____
_____

Print Patient Name: _____ Date: _____

Signature: _____