ABOUT YOU

Date: ________________ Chart #: ______________

Patient's Name: ________________________________

Called Name: __________________________________

Parent/Guardian Name: __________________________

Marital Status: M__ S__ W__ D__

Birth date: __/__/_____ Age: ____ Sex: M ___ F ___

Address: ______________________________________

City: ________________ State: ______ Zip: ________

Home Phone: ______________ Cell: ________________

Preferred Contact Number: ______________________

Email: ____

Name of spouse ________________________________

Name of nearest relative not living with you:

________________________ Phone: ______________

Whom may we thank for referring you?

____

For Women: Are you taking birth control? ___ Y ___ N

Are you pregnant? ____ Y ____ N How Long?_________

Electronic Health Records Info

Height: _____ Weight: _____ Blood Pressure: _________

Are you being treated for high blood pressure? Yes No

Race: Caucasian_____African American_____ American Indian_____Alaska Native_____Asian_____Native Hawaiian_____Other Pacific Islander_____Decline_____

Ethnicity: Hispanic or Latino_____

Not Hispanic or Latino_____Decline to answer _____

Language: ______________________________

Do you smoke? ___Yes ___No # of packs per day? _____

How many years have you been smoking? _________

Do you drink alcoholic beverages? ___ Yes ___No

List all prescription, non -prescription medications and supplements you take as well as the **associated condition**:

____

____

____

____

List anything you are allergic to: ________________

____

Family History (list all major diseases and relation to you of the individual): ________________________________

____

____

____

WELCOME

THE BALANCED BODY CENTER
10550 Independence Pointe Pkwy Ste. 100
Matthews, NC 28015
704-849-9393
www.knowbalance.com

HEALTH INFORMATION

What is your major complaint? ______________

____

____

How long have you had this condition? _________

What activities aggravate the condition? _________

____

____

Is this condition getting progressively worse?

☐ Y ☐ N ☐ constant ☐ comes and goes

Is this condition interfering with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Others who treated this condition:

____

List surgical operations and years:

____

____

____

____

Have you had previous Chiropractic Care? __Y __ N

Where? ____

When? ____

Why? ____

Were X-rays taken? _____________________________

Have you been in an auto accident? Yes No

When? ____

Describe: ______________________________________

____

____

List any other personal injury or accident.

When? ____

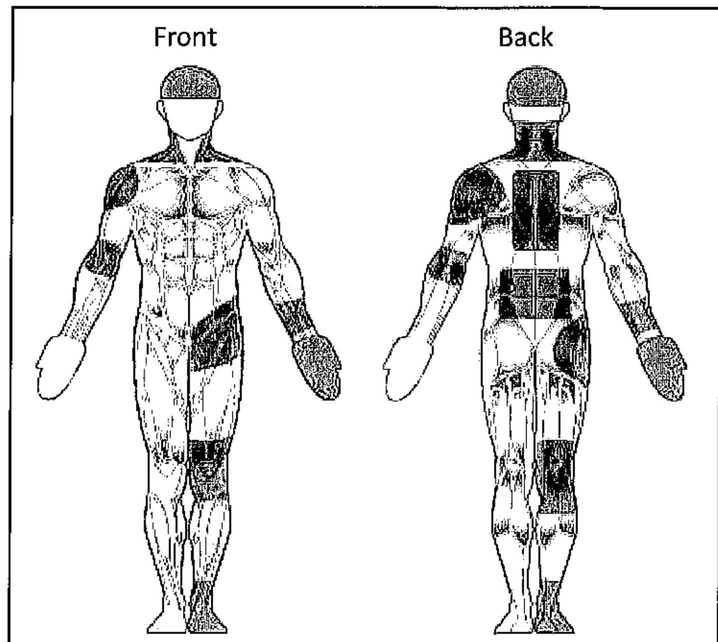
Describe: ______________________________________

____

____

Structural Care Patients

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



Numbness – use dash marks i.e. -----

Pins & Needles – use circles i.e. ooooo

Burning – use jagged line i.e. ^^^^^^^^

Stabbing – use solid dots i.e. ●●●●●

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual, understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. Our office will furnish you with the appropriate forms to be submitted to the insurance company, a maximum of two times per claim. If the claim is rejected more than two times, it will be your responsibility to pay for this service and file for reimbursement with the insurance company. Services such as blood work, EKG, Spirometry, and Doppler may be deemed unnecessary by insurance companies and therefore payment is required at time of service.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_______________________________________ ____________________

Patient or Legally Authorized Individual Signature Date

BALANCED BODY CENTER

Notice of Privacy Practices

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: ____ Date: _________________________________

With whom may we discuss your care:

Name: _______________________________________ Relation: __________________________________

Name: _______________________________________ Relation: __________________________________

Name: _______________________________________ Relation: __________________________________

How should we contact you?

Phone 1st choice ______________________________________

2ND choice ______________________________________

e-mail ______________________________________

If you prefer to be contacted by phone, may we leave a message -

on the voice mail? Yes No

with the person answering the phone? Yes No

The Balanced Body Center
Dr. Philip A. Arnone, D.C., DABCI
Dr. Derek Farmen, DC
Susan B. Moses, MSPT
10550 Independence Pointe Parkway Suite 100
Matthews, NC 28105

Thank you for choosing ***The Balanced Body Center*** for your health needs. We can assure you we will do our utmost to deserve your confidence. In order for us to serve all of our patients we have some policies we request that you comply with.

Our goal is to help you and your family lead an active, healthy, pain-free life through chiropractic care, exercise and nutrition. We will do our best to get you on the road to recovery in the least amount of time possible. Additionally, we will educate you and your family on ways to prevent problems in the future.

Our office is open Monday through Friday. Office staff can be reached between the hours of 8:00 AM to 7:00 PM. Specific hours for doctors are posted at the front desk.

Please schedule appointments in advance. Doing so will enable you to schedule your appointment at a time that is most convenient for you. Our chiropractic assistants will help you if there is a need to reschedule an appointment.

Your doctor will suggest a series of appointments according to your treatment plan. For optimum results, please follow this treatment plan as closely as possible. If you find that you must rearrange one of your appointments, please try to make that appointment up within the next day or two.

We realize that your time is valuable and we will do our best to get you in to see the doctor as close to your appointment time as possible. We ask that you be considerate of others and be on time for your appointment. If you must miss an appointment, please call us. The doctors are very busy, and we can schedule someone else at your appointment time.

After your initial visit, the doctor will prepare an individualized treatment plan for you. One of our chiropractic assistants will review the financial portion of the plan with you. We accept cash, checks, VISA, MasterCard, and Discover. Additionally, we will be happy to keep your credit card on file for your convenience.

If there is any way we can be of assistance, please let us know.

Yours in health,
The Balanced Body Center

I have read, understand and agree to the policies stated above. I understand and agree that, regardless of insurance status, I am ultimately responsible for the balance on my account and for any professional services rendered.

Signature:______________________________________ Date:____________________

THE BALANCED BODY CENTER
Philip A Arnone, D.C., DABCI
Derek S Farmen, D.C.

Attention: Patients that intend to use your personal health insurance to pay for any portion of care in this office:

The Doctors utilize a treatment technique that requires taking "post x-rays" of the cervical spine. Many of the referrals our chiropractors receive are because of this procedure. Because these x-rays (Rarely more than 2 – usually just 1) are not for ***initial*** diagnosis purposes, insurance companies do not and will not pay for them. To ***objectively*** evaluate your progress, these films are necessary (if your condition warrants the taking of cervical x-rays). These x-rays range from $30-$75 each.

I understand that I am responsible for the post x-ray charges, and I intend to comply with the above policy.

__________________________________ ____________________
Signature Date

The Balanced Body Center
Dr. Philip A. Arnone, D.C., DABCI
Dr. Derek Farmen, DC
Susan Moses,MSPT
10550 Independence Pointe Pkwy Ste 100
Matthews NC 28105
704-849-9393

Patient Name: ___________________________

Welcome to our office. We look forward to helping you achieve your health-related goals. Dr. Arnone and Dr. Farmen are Chiropractors but they practice Functional Medicine.

Because of the work Dr. Arnone and Dr. Farmen do with patients, they like to keep your primary care physician up to date with your progress here in our office. If you would like for the doctors to share your progress and results with your primary care physician, please complete the information below.

Primary Care Physician: ____

Office Name: ____

Office Location: ____

Office Phone: _________________________

Office Fax: _________________________

The Balanced Body Center

X-ray Consent & Pregnancy Release Form

Patient Name: ____

DOB: __________________________

Please answer the following questions:

1. Are you pregnant or any chance you may be? _______
2. Date of the start of your last period? _______________
3. Are you on any type of birth control? ______________
4. Are you trying to get pregnant? Yes / No

Your Signature indicates that you have read, understood, and answered all of the above and accept all responsibilities associated with exposure to yourself and your unborn child and have accurately answered the above statements.

Signature: _______________________________ Date: _____________

Witness: ________________________________ Date: _____________

PATIENT DIAGNOSTIC QUESTIONNAIRE
The Balanced Body Center

Name________________________________ Today's Date ______ Age __________

001 How much do you weigh? ______________

Your chief complaints:
Please mark with an (x) the principle or major conditions which you are concerned about, would like eliminated, or desire treatment for:

002 ( ) Overweight
003 ( ) Underweight
004 ( ) Sexual Problems
005 ( ) Menopause Problems
006 ( ) Heart Condition
007 ( ) Blood Pressure
008 ( ) Digestion Trouble
009 ( ) Gall Bladder Problems
010 ( ) Diabetes Mellitus
011 ( ) Skin Disorder
012 ( ) Ear or Hearing Disorder
013 ( ) Sinus Infections
014 ( ) Nervous/Emotional Trouble
015 ( ) Allergies to Food
016 ( ) Nutritional Evaluation
017 ( ) Arthritis/Rheumatism
018 ( ) Headaches
019 ( ) Female Problems
020 ( ) Extreme Fatigue
021 ( ) Cancer
022 ( ) Circulatory Problems
023 ( ) Lung and/or Breathing
024 ( ) Stomach and/or Gall Bladder
025 ( ) Intestine or Bowel Trouble
026 ( ) Neck and/or Spine Problems
027 ( ) Eye Condition
028 ( ) Nose/Throat/Mouth Problems
029 ( ) Dizziness/Balance Disorder
030 ( ) Kidney/Bladder/Urinary
031 ( ) Allergies in General
032 ( ) Thorough Diagnostic Checkup
033 ( ) Alcohol or Tobacco Addiction

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS QUESTIONAIRE.

- Read each question carefully and mark with an (x) only those statements which are true for you (a yes answer)
- If a question does not apply to you, or you do not recognize the terminology or disease, or if you are not sure and have a doubt about a question, then do not check the box, simply leave it blank.

GENERAL

034 ( ) Are you overweight?
035 ( ) Are you underweight?
036 ( ) Are your fingernails ridged or have white spots?
037 ( ) Do you sleep less than 7 hours per night?
038 ( ) Do you rarely exercise?
039 ( ) Do you smoke over 9 cigarettes each day or inhale pipe/cigars?
040 ( ) Do you drink alcoholic beverages each day?
041 ( ) Do you usually drink less than 8 glasses of water each day?
042 ( ) Are you sensitive to chemicals, paint, exhaust fumes, cologne?
043 ( ) Are you unable to recall your dreams the next day?

EYES

044 ( ) Are you near sighted /can't see things at a distance?
045 ( ) Are you far sighted / can't read small print w/o glasses?
046 ( ) Do your eyes frequently itch?
047 ( ) Do you suffer from cross eyes?
048 ( ) Do you have or have you had cataracts?
049 ( ) Do you experience pain in your eyes?
050 ( ) Are your eyes bloodshot?
051 ( ) Do your eyes water?
052 ( ) Do your eyes feel gritty?
053 ( ) Is your vision blurred?

EARS

054 ( ) Are you hard of hearing?
055 ( ) Are you experiencing any discharge from your ears?
056 ( ) Do you have ringing or noises in your ears?
057 ( ) Do you suffer from recurrent ear infections?
058 ( ) Do you have a punctured ear drum?

MOUTH and THROAT

059 ( ) Is your tongue badly coated?
060 ( ) Do you have bad breath?
061 ( ) Do you suffer from sores or cracks at the corners of your mouth?
062 ( ) Do you frequently experience canker sores?
063 ( ) Are your gums sore?
064 ( ) Do you frequently suffer from fever blisters?
065 ( ) Do your gums bleed when you brush?
066 ( ) Do you frequently have a sore throat?
067 ( ) Are your glands often swollen?
068 ( ) Do you suffer from toothaches?
069 ( ) Is your mouth often dry?
070 ( ) Do you have excessive saliva?
071 ( ) In the mornings, do you have a bitter taste in your mouth?
072 ( ) Do you frequently have a sore tongue?

RESPIRATORY

073 ( ) Do you have frequent colds?
074 ( ) Do you suffer from nasal polyps?
075 ( ) Do you often have sinus infections?
076 ( ) Do you experience night sweats?
077 ( ) Do you have hay fever?
078 ( ) Do you wheeze?
079 ( ) Do you have asthma?
080 ( ) Do you experience difficulty breathing?
081 ( ) Do you have a chronic cough?
082 ( ) Do you spit up phlegm?
083 ( ) Do you spit up blood?
084 ( ) Do you have spells of sneezing?
085 ( ) Is your nose frequently stuffy?
086 ( ) Does your nose run constantly?
087 ( ) Do you have frequent nose bleeds?
088 ( ) Do you catch severe colds?
089 ( ) Do you have a chronic chest congestion?
090 ( ) Do you have post nasal drip?

CARDIOVASCULAR

091 ( ) Do you have high blood pressure?
092 ( ) Do you have low blood pressure?
093 ( ) Do you have pains in the heart or chest?
094 ( ) Are you troubled with blood clots?
095 ( ) Do you have cold hands?
096 ( ) Are your feet frequently cold?
097 ( ) Do you have varicose veins?
098 ( ) Are your ankles frequently swollen?
099 ( ) Do you have an unusually slow pulse rate?
100 ( ) Do you experience spells of rapid heart beat?
101 ( ) Are you aware of your heart skipping beats?
102 ( ) Do you experience shortness of breath while sitting still?
103 ( ) Do you suffer from leg cramps after retiring to bed?
104 ( ) Do you suffer from leg cramps during the day?
105 ( ) Do you experience pain in your legs/ hips when walking?

GASTROINTESTINAL

106 ( ) Is your appetite poor?
107 ( ) Do you have excessive hunger?
108 ( ) Do you experience fainting spells when hungry?
109 ( ) Does eating relieve fatigue?
110 ( ) Do you feel shaky when hungry?
111 ( ) Are you frequently drowsy after eating a meal?
112 ( ) Do you eat when nervous?
113 ( ) Do you frequently have diarrhea?
114 ( ) Do you have difficulty in swallowing?
115 ( ) Do you vomit frequently?
116 ( ) Are you frequently nauseated?
117 ( ) Are you bloated after eating meals?
118 ( ) Do you have abdominal gas?
119 ( ) Does eating greasy foods cause you to have indigestion?
120 ( ) Do you belch/burp after eating?
121 ( ) Do you have indigestion immediately upon eating?
122 ( ) Do you have indigestion within 1 hour after meals?
123 ( ) Do you have indigestion 2 hours or more after meals?
124 ( ) Do you have loose bowel movements?
125 ( ) Have you ever had intestinal worms?
126 ( ) Do you have pale or yellow colored stool?
127 ( ) Do you suffer from constipation?
128 ( ) Do you have one or less bowel movement daily?
129 ( ) Are your stools bloody?
130 ( ) Do you have black tarry stool?
131 ( ) Do you use laxatives?
132 ( ) Do you suffer from severe abdominal pains?
133 ( ) Do you have hemorrhoids?
134 ( ) Do you have stomach ulcers?
135 ( ) Do you have gall bladder disease?
136 ( ) Do you have liver disease?

NEUROMUSCULAR

137 ( ) Do you have neck pain?
138 ( ) Do you have pain between the shoulders?
139 ( ) Do you suffer from low back pain?
140 ( ) Do you have swollen joints?
141 ( ) Do you have spinal curvature?
142 ( ) Do you suffer from muscle spasms?
143 ( ) Are your muscles frequently sore?
144 ( ) Do you have muscle weakness?
145 ( ) Are your joints stiff in the morning?
146 ( ) Do you suffer from leg pain?

147 ( ) Do you suffer from leg pain?

148 ( ) Do you have rheumatism?

149 ( ) Does any part of your body experience numbing or tingling?

150 ( ) Do you have frequent headaches?

151 ( ) Are you often dizzy?

152 ( ) Do you frequently feel faint?

153 ( ) Do you have epilepsy?

154 ( ) Do you bite your nails badly?

155 ( ) Do you stutter or stammer?

156 ( ) Are you a sleep walker?

157 ( ) Do you have rheumatoid arthritis?

158 ( ) Do you have osteoarthritis?

159 ( ) Do you suffer from motion sickness?

FEET

160 Do you suffer from painful feet?

161 ( ) Do you have frequent foot cramps?

162 ( ) Do you have plantar warts?

163 ( ) Do you have heel spurs?

164 ( ) Are you troubled with corns?

SKIN

165 ( ) Is your skin tender?

166 ( ) Does your skin itch?

167 ( ) Do you have skin eruptions?

168 ( ) Is your skin rough, especially on the back of your arms?

169 ( ) Do you have Psoriasis?

170 ( ) Do you bruise easily?

171 ( ) Do you have acne?

172 ( ) Are you troubled with boils?

173 ( ) Do you have Eczema?

174 ( ) Are you aware of moles which are changing in size or color?

175 ( ) Do you frequently experience goose bumps?

176 ( ) Do you have hives (allergy reaction to the skin)?

177 ( ) Do you have excessive perspiration?

178 ( ) Do you get sores that are slow to heal?

URINARY

179 ( ) Do you have frequent urination?

180 ( ) Do you awaken at night to urinate?

181 ( ) More than one time

182 ( ) More than two times?

183 ( ) More than three times?

184 ( ) Are you a bed wetter?

185 ( ) Do you leak urine when sneezing or laughing?

186 ( ) Mild?

187 ( ) Moderate?

188 ( ) Severe?

189 ( ) Have you ever lost control of your bladder?

190 ( ) Do you have painful urination?

191 ( ) Do you have blood in your urine?

192 ( ) Do you require a urinary control device or pad?

193 ( ) Do you have difficulty in starting the stream?

194 ( ) Do you have frequent bladder infections?

195 ( ) Do you have frequent kidney infections?

196 ( ) Do you have kidney stones?

ENDOCRINE

197 ( ) Do you have excessive thirst?

198 ( ) Is your skin coarse?

199 ( ) Do you frequently feel cold?

200 ( ) Do you frequently hot?

201 ( ) Are you unusually tired most of the time?

202 ( ) Are you unusually jumpy or nervous?

203 ( ) Is your hair coarse?

204 ( ) Are you diabetic?

204 ( ) Are you diabetic?

205 ( ) Do you get lightheaded when standing quickly?

FOR WOMEN ONLY

206 ( ) Do you have painful periods?
207 ( ) Do you have an excessive flow?
208 ( ) Do you have irregular cycles?
209 ( ) Do you suffer from menstrual cramps?
210 ( ) Do you have hot flashes?
211 ( ) Do you have vaginal discharge?
212 ( ) Do you have a bloody spotting discharge?
213 ( ) Have you had a hysterectomy?
214 ( ) Do you retain fluid during your periods?
215 ( ) Have you ever miscarried?
216 ( ) Do you have acne worse at menstruation?
217 ( ) Do you have tender breasts?
218 ( ) Do you have frequent yeast infections?
219 ( ) Do you have lumps in your breasts?
220 ( ) Do you have heavy hair growth on your face or body?
221 ( ) Do you take birth control pills?
222 ( ) Do you have pre-menstrual depression?
223 ( ) Is intercourse painful for you
224 ( ) Do you have vaginal laxity?
225 ( ) Do you have a diminished sex desire?
226 ( ) Do you have poor or infrequent orgasm?
227 ( ) Do you have vaginal dryness?

FOR MEN ONLY

228 ( ) Do you have painful genitals?
229 ( ) Do you have prostate troubles?
230 ( ) Do you have lumps in your testicles?
231 ( ) Do you have a discharge from the urethra?
232 ( ) Do you have sores on external genitalia?
233 ( ) Do you have difficulty getting or keeping an erection?
234 ( ) Do you have difficulty completing intercourse?
235 ( ) Have you had difficulty fathering children?

BEHAVIORAL

236 ( ) Do you have difficulty falling asleep?
237 ( ) Do you have difficulty staying asleep?
238 ( ) Do you have recurrent bad dreams?
239 ( ) Do you have difficulty in concentrating?
240 ( ) Is your memory poor?
241 ( ) Do strange people or places make you afraid?
242 ( ) Are you scared to be alone?
243 ( ) Do you always need someone to advise you?
244 ( ) Are you afraid to eat anywhere except at home?
245 ( ) Are you unhappy when others are happy?
246 ( ) Are you unusually unhappy and depressed?
247 ( ) Do you often cry?
248 ( ) Are you frequently miserable or blue?
249 ( ) Do you wish you were dead and away from it all?
250 ( ) Are your feelings easily hurt?
251 ( ) Does criticism always upset you?
252 ( ) Do people usually misunderstand you?
253 ( ) Do you have to be on guard even with your friends?
254 ( ) Do people often annoy you?
255 ( ) Are you easily angered?
256 ( ) Do you frequently become scared for no reason?
257 ( ) Do you feel you are under considerable emotional stress?

LIFESTYLES

258 ( ) Do have high cholesterol?
259 ( ) Do you exercise at least 3 times a week?
260 ( ) Do you eat 3 or more fruits a day?
261 ( ) Do you eat 3 or more vegetables a day?
262 ( ) Do you drink more than 1 cup/glass of coffee, tea, or soda per day?
263 ( ) Do you drink water daily?

MEDICATIONS (Please note how long you have been taking each medication)

____

____

____

____

____

____

FOR DOCTOR'S USE ONLY
Foundations of Health

Structure

Nutrition

Exercise

Genetics

Psychology