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DATE \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ EMAIL \_\_\_\_\_  
(Required)

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SS# \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ DL# \_\_\_\_\_ MALE / FEMALE \_\_\_\_\_

SPOUSE \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_

# OF CHILDREN \_\_\_\_\_ NAMES AND AGES OF CHILDREN \_\_\_\_\_

Name/Number of Emergency Contact \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

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What is your main complaint? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or a similar condition in the past? \_\_\_\_\_

How serious do you think this problem is? \_\_\_\_\_

This is a new  old  illness. It was  was not  treated before.

If treated before, what was done? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No Is this condition:  Constant? Or does it  Come and go?

What different remedies have you tried to help your problem? \_\_\_\_\_

How frustrated are you that you still have the complaint? \_\_\_\_\_

How motivated are you to get rid of your problem? \_\_\_\_\_

Other complaints? \_\_\_\_\_

Have you ever had Chiropractic care before?  Yes  No How long ago? \_\_\_\_\_

Name of chiropractor \_\_\_\_\_

When was the last time you had spinal X-rays? \_\_\_\_\_

What is the name of your primary care doctor?: \_\_\_\_\_

Where is your doctor located? \_\_\_\_\_

Have you ever had surgery or been hospitalized?  Yes  No

List Surgeries (include dates): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What medications do you now take? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Female: Are you pregnant at this time?  Yes  No Date of last period: \_\_\_\_\_

From birth to present please list date and describe:

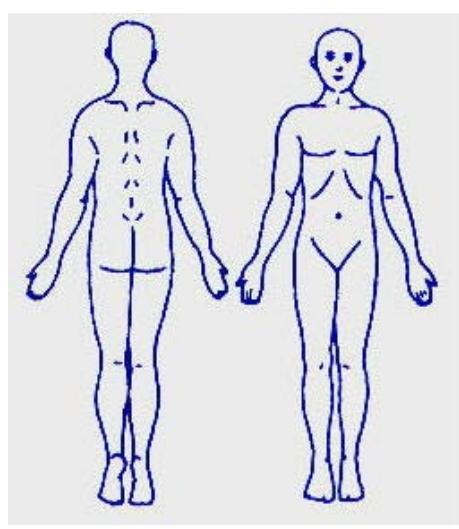
1) Car accidents \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Falls / Injuries (Including Sports) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Other injuries \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

On the diagram below,  
please outline the area of your discomfort  
A=Aches B=Burning N=Numbness  
P=Pins & Needles S=Stabbing O=Other



Do you now have or have you recently had any of the following?

#### HEAD:

- Headache
  - sinus (allergy)
  - entire head
  - back of head
  - forehead
  - temples
  - migraine
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of taste
- Loss of balance
- Dizziness
- Loss of hearing
- Pain in ears
- Ringing in ears
- Buzzing in ears

#### NECK:

- Pain in neck
- Neck pain with movement
  - Forward
  - Backward
  - Turn to left
  - Turn to right
  - Bend to left
  - Bend to right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

#### SHOULDERS:

- Pain in shoulder joint [R L]
- Pain across shoulders
- Bursitis [R L]
- Arthritis [R L]
- Can't raise arm
  - above shoulder level
  - over head
- Tension in shoulders
- Pinched nerve in shoulder [R L]
- Muscle spasms in shoulder

#### ARMS & HANDS:

- Pain in upper arm [R L]
- Pain in elbow [R L]
- Movement aggravated
- Tennis elbow [R L]
- Pain in forearm [R L]
- Pain in hands [R L]
- Pain in fingers [R L]
- Pins & needles in arms [R L]
- Pins & needles in fingers [R L]

#### ARMS & HANDS (cont):

- Numbness in arms [R L]
- Numbness in fingers [R L]
- Fingers go to sleep [R L]
- Hands cold [R L]
- Swollen joints in fingers [R L]
- Sore joints in fingers [R L]
- Arthritis in fingers [R L]
- Loss of grip strength [R L]

#### MID-BACK:

- Mid-back pain
- Location \_\_\_\_\_
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Pain from front to back
- Muscle spasms
- Pain in kidney \_\_\_\_\_ area

#### CHEST:

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange-peel breast
- Irregular heartbeat

#### ABDOMEN:

- Nervous stomach
- Foods can't eat \_\_\_\_
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

#### LOW BACK:

- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroiliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when \_\_\_\_\_
- Slipped Disc
- Low back feels out of place
- Muscle spasms
- Arthritis

#### HIPS, LEGS, & FEET:

- Pain in buttocks [R L]
- Pain in hip joint [R L]
- Pain down leg [R L]
- Pain down both legs
- Knee pain [R L]
  - Inside
  - Outside
- Leg cramps [R L]
- Cramps in feet [R L]
- Pins & needles in leg [R L]
- Numbness of leg [R L]
- Numbness of feet [R L]
- Feet feel cold [R L]
- Swollen ankles [R L]
- Swollen feet [R L]

#### WOMEN ONLY:

- Menstrual pain (where)
- Cramping
- Irregularity
- Cycle \_\_\_\_\_ days
- Birth control \_\_\_\_\_(type)
- Hysterectomy
- Genital cancer
- Discharge
- Menopause
- Tumors
- Abortions
- Are you or do you think you might be pregnant?

#### MEN ONLY:

- Frequent urination
- Difficulty in starting
- Night urination
- Prostate pain/swelling

#### GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feeling run-down
- Normal sleep
- Loss of sleep \_\_\_\_hrs./night
- Loss of weight \_\_\_\_lbs.
- Gain weight \_\_\_\_lbs.
- Coffee \_\_\_\_cups/day
- Tea \_\_\_\_\_ cups/day
- Cigarettes \_\_\_\_ pack/day
- Diabetes
- Hypoglycemia
- Other \_\_\_\_\_

#### REMARKS:

Please take several minutes to answer these questions so Dr. Kaplan can help you get better faster.  
**(Please circle as many that apply)**

1. How have you taken care of your health in the past?

- a. Medications
- b. Emergency Room
- c. Routine Medical
- d. Exercise
- e. Nutrition/Diet
- f. Holistic Care
- g. Vitamins
- h. Chiropractic
- i. Other (please specify): \_\_\_\_\_

2. How did the previous method(s) work out for you?

- a. Bad results
- b. Some results
- c. Great results
- d. Nothing changed
- e. Did not get worse
- f. Did not work very long
- g. Still trying
- h. Confused

3. How have others been affected by your health condition?

- a. No one is affected
- b. Haven't noticed any problem
- c. They tell me to do something
- d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

- a. Job
- b. Kids
- c. Future ability
- d. Marriage
- e. Self-esteem
- f. Sleep
- g. Time
- h. Finances
- i. Freedom

5. Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic Fatigue
- i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

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What has that cost you? (e.g. - time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

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What are you most concerned with regarding your problem? \_\_\_\_\_

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Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

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What would be different/better without this problem? Please be specific \_\_\_\_\_

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What do you desire most to get from working with us? \_\_\_\_\_

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What is that worth to you? \_\_\_\_\_

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I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

It is understood and agreed any amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

**Patient's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## The Body Balance Test

To easily check your stress levels, read the following items and check the ones that apply to you. Then read below to interpret the results.

Do you generally:

- |  |   |
|--|---|
| <input type="checkbox"/> Crave starches and sweets?                              | <input type="checkbox"/> Yawn a lot during the day?                               |
| <input type="checkbox"/> Fail to eat a good, healthy breakfast?                  | <input type="checkbox"/> Feel depressed or sad once a week or more?               |
| <input type="checkbox"/> Eat pasta daily?  | <input type="checkbox"/> Suffer from allergies?                                   |
| <input type="checkbox"/> Drink juices, soda, or other sweet drinks?              | <input type="checkbox"/> Wake up tired in the morning?                            |
| <input type="checkbox"/> Need a cup of coffee or tea to get going every morning? | <input type="checkbox"/> Feel nervous and irritable?                              |
| <input type="checkbox"/> Eat margarine in place of butter?                       | <input type="checkbox"/> Drink any alcoholic beverages daily?                     |
| <input type="checkbox"/> Tend to eat low-calorie meals and drink diet sodas?     | <input type="checkbox"/> Have trouble falling asleep?                             |
| <input type="checkbox"/> Eat fried foods daily?                                  | <input type="checkbox"/> Wake up in the wee hours of the morning unable to sleep? |
| <input type="checkbox"/> Binge on sweets more than once a week?                  | <input type="checkbox"/> Have difficulty losing weight?                           |
| <input type="checkbox"/> Feel tired late in the afternoon?                       | <input type="checkbox"/> Have low sexual energy?                                  |
| <input type="checkbox"/> Feel sleepy after dinner?                               | <input type="checkbox"/> Have difficulty remembering things?                      |
| <input type="checkbox"/> Find it's hard to stay focused at work?                 | <input type="checkbox"/> Have periods of anxiety?                                 |
| <input type="checkbox"/> Frequently get headaches?                               | <input type="checkbox"/> Frequently get constipated?                              |
| <input type="checkbox"/> Frequently feel light-headed?                           | <input type="checkbox"/> Experience muscle pain or spasms?                        |
|  | <input type="checkbox"/> Have low or high blood pressure?                         |

**If you answered “yes” to more than six of these questions, you could very well be experiencing some of the negative effects of stress. If you’ve answered “yes” to more than twelve of these questions, stress is seriously affecting the quality of your life. Your pH is very likely registering on the acid side, and your hormones are out of balance. Your body is in perpetual distress cycle.**