

Balanced Body Chiropractic Center, LLC  
Dr. Jacqueline D. Flynn  
Dr. Jenny Bess Lennon  
223 Meadow Street  
Naugatuck, CT 06770  
203-723-5715

*You ought not to attempt to cure eyes without head, or head without body, so you should not treat body without soul*  
- Socrates

## Patient History

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status    S    M    D    W    Number of Children and Ages \_\_\_\_\_

Social Security # \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Referred By \_\_\_\_\_ and \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

### **Insurance/Accident Information**

Insurance Co. \_\_\_\_\_ Name of Insured \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Date/Birth \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Is this condition/Pain the result of an accident?    \_\_\_ Yes    \_\_\_ No    \_\_\_ Work    \_\_\_ Auto    \_\_\_ Other

Date of Accident \_\_\_\_\_ Nature of Accident \_\_\_\_\_

### **Medical Release/Assignment of Benefits**

I authorize Balanced Body Wellness Center to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Balanced Body Wellness Center. I understand that I am fully responsible for any unpaid or unassigned portion of charges incurred at this office.

**Regardless of insurance status, charges for services rendered at this office are ultimately the patient's responsibility. If your insurance requires a referral prior to treatment in our office, it is your responsibility to provide us with that referral.**

**I understand that Dr. Jacqueline Flynn requires 12 hours notice prior to canceling an appointment. A \$25 charge will be applied to your bill otherwise. This charge is not covered by insurance and is your responsibility.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**(Parent or guardian of minor)**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **General Health Information**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Left/Right Handed \_\_\_\_\_

Have you ever received chiropractic care before? Yes / No Drs. Name \_\_\_\_\_

Have you undergone previous chiropractic or physical therapy during this calendar year? \_\_\_\_\_

List any diseases or health conditions you now have, or have been treated for in the past. (Give a brief description):

\_\_\_\_\_

List any known allergies: \_\_\_\_\_

List any other traumas or injuries: \_\_\_\_\_

List any hospitalizations or surgeries: \_\_\_\_\_

When was your last complete physical? \_\_\_\_\_ Blood Tests \_\_\_\_\_ X-rays \_\_\_\_\_

Other Tests (describe) \_\_\_\_\_ Results? \_\_\_\_\_

Who is your primary doctor? \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit to primary doctor: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Please list **all** medications, including birth control pills, aspirin, cortisone or vitamins and herbs that you are presently taking. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## **Women Only**

Are you pregnant, or think you may be pregnant? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Do you have or have you suffered from any menstrual disorders? \_\_\_\_\_

If yes, please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## **Men Only**

Do you suffer from any bladder/urinating problems? \_\_\_\_\_

If yes please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of last prostate exam \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Family History** - Check all that apply

	Stroke	Heart Disease	Arthritis	Cancer	Diabetes	Thyroid	Other
Mother's Side	___	___	___	___	___	___	___
Father's Side	___	___	___	___	___	___	___

**Current Symptoms**

Reason for consulting the doctor today: \_\_\_\_\_  
 When did this pain or condition begin? \_\_\_\_\_ Pain is: \_\_\_Sharp \_\_\_Dull \_\_\_Constant \_\_\_Intermittent  
 Rate your pain on a scale from 0 - 10 (0=No pain, 10=Severe Pain), please circle: **1 2 3 4 5 6 7 8 9 10**  
 Does your pain radiate or move? Describe: \_\_\_\_\_  
 What aggravates your condition/pain? \_\_\_\_\_  
 What relieves your condition/pain? \_\_\_\_\_  
 Is the condition worse at certain times of the day? When? \_\_\_\_\_  
 Activities limited due to your condition: \_\_\_\_\_  
 Is the condition getting progressively worse? \_\_\_\_\_  
 Previous doctors or treatments: \_\_\_\_\_  
 Any home remedies used? \_\_\_\_\_  
 Have you ever had same/similar condition before? Explain: \_\_\_\_\_

**Check any of the following symptoms, which you have now or have had in the past. N=now P=past**

- |                                    |   |                                  |
|------------------------------------|---|----------------------------------|
| ___ Headaches                      | ___ Pins & Needles in Arms/Legs                 | ___ Cold Hands/Feet              |
| ___ Neck Pain                      | ___ Numbness in Fingers/Toes                    | ___ Panic Attacks                |
| ___ Back Pain                      | ___ Feeling of Anxiety                          | ___ Stomach upset/Ulcers         |
| ___ Chest Pain                     | ___ Irregular Heart Rate                        | ___ Irritable bowel/Colitis      |
| ___ Neck Stiff                     | ___ Shortness of Breath/Asthma                  | ___ Leg/feet cramps at night     |
| ___ Ears Ring/Buzz                 | ___ Tension/Irritability                        | ___ Unexplained Fever            |
| ___ Sleeping Difficulties          | ___ High Blood Pressure                         | ___ Eczema/Skin Rashes           |
| ___ Clench/Grind Teeth             | ___ Cold Sores/Fever Blisters                   | ___ Severe Menstrual Cramps      |
| ___ Dizziness/Vertigo              | ___ Depression/S.A.D.                           | ___ Chronic Fatigue              |
| ___ Roving muscle/joint Pain       | ___ Alcoholism/Addictions                       | ___ Eyes very sensitive to light |
| ___ Recent unexplained weight loss | ___ Recent change in bowel/ or bladder function |                                  |

I certify that I have read and understand all the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## About Holistic Health Care

Balanced Body Wellness Center strives to encompass all aspects of your being to bring whole health to your mind, body and spirit. One's optimum health potential will be reached only when a "balance" exists between these three components. Pain and disease are often "symptoms" which result from imbalance in our lives. This form will aid us in discovering symptoms and "dis-ease" which may be related to imbalances in your life. Be assured that immediate referral will be made with the discovery of any disease or symptom which necessitates more immediate and specialized medical care. Those who are in need of more specialized medical intervention will often benefit from the addition of holistic chiropractic health care as well as other services offered at our center.



### The Body

### Comments

- Yes / No Do you exercise regularly? In what way? \_\_\_\_\_
- Yes / No Do you eat properly? What foods do you crave? \_\_\_\_\_
- Yes / No Do you drink alcohol? Avg. daily intake? \_\_\_\_\_
- Yes / No Do you consume caffeinated beverages? Avg. daily intake? \_\_\_\_\_
- Yes / No Do you smoke? Average daily amount? \_\_\_\_\_
- Yes / No Difficulty sleeping or falling asleep? Avg. hours of sleep? \_\_\_\_\_
- Yes / No Are you taking any drugs? (Prescriptive or non-prescriptive) \_\_\_\_\_
- Yes / No Do you take vitamins or natural remedies? Explain: \_\_\_\_\_



### The Mind

- Yes / No Do you often feel rushed? \_\_\_\_\_
- Yes / No Do you easily lose your train of thought? \_\_\_\_\_
- Yes / No Is it difficult to shut off or slow your thoughts? \_\_\_\_\_
- Yes / No Are you intolerant of other's mistakes? \_\_\_\_\_
- Yes / No Do you prefer to be in control of situations? \_\_\_\_\_
- Yes / No Is it difficult to motivate yourself? \_\_\_\_\_



### The Spirit

- Yes / No Do you consider yourself spiritual? \_\_\_\_\_
- Yes / No Do you feel a strong sense of purpose? \_\_\_\_\_
- Yes / No Are you satisfied with your life? \_\_\_\_\_
- Yes / No Do you pray or meditate regularly? \_\_\_\_\_

## Life Events - Check any of the following that have occurred within the last 3 years

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Death of a Loved One      | <input type="checkbox"/> Divorce/Separation         | <input type="checkbox"/> Marriage/Family Additions |
| <input type="checkbox"/> Job/Career Change         | <input type="checkbox"/> Personal injury/illness    | <input type="checkbox"/> Illness of a Loved One    |
| <input type="checkbox"/> Change of Residence       | <input type="checkbox"/> Change in Financial Status | <input type="checkbox"/> A Difficult Relationship  |
| <input type="checkbox"/> Starting/Finishing School | <input type="checkbox"/> Child Leaving Home         | <input type="checkbox"/> Business Difficulties     |

List any major life events, (good or bad), which you anticipate within the next year: \_\_\_\_\_

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## CANCELLATION POLICY

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Canceling an appointment with insufficient notice prevents us from scheduling another patient in your time slot. Any appointment not cancelled with 24 hours notice will be charged for an office visit under the following policy:

- » If you cancel or change your appointment with 24 hour notice there is NO charge.
- » Any appointments not cancelled with 24 hour notice will be charged \$25 for the time reserved. This fee may be waived if another patient schedules in the available slot, or it is determined by the practitioner that an unavoidable emergency has occurred.
- » Not showing up for an appointment will be billed at \$25, since the time has been reserved specifically for you.

Please provide us with a valid credit card number in the event that you miss an appointment without cancellation.

I have read, understood, and agree to the terms of this policy as it is stated. I give Balanced Body Wellness Center, LLC permission to charge the card below if I do not cancel an appointment with proper notice.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Name on Card

\_\_\_\_\_  
Visa/MasterCard Account Number  
(please circle which one)

\_\_\_\_\_  
CRV #

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date