total balance
CHIROPRACTIC

Aging is influenced by many factors. Your questionnaire provides valuable information which helps us understand the underlying causes of your health concerns. Please fill out the questions to the best of your ability and bring the form with you to your first visit to us.

General Info

Name: _____ Date:_____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ ○ Male ○ Female

Home #: _____ Work #: _____Cell #: _____

Contact # Preference ○ Home ○ Work ○ Cell

Email address: _____Occupation: _____

Emergency Contact: _____ Phone #:_____

Relationship: _____

Primary Physician: _____ Phone #:_____

Facial Concerns

Please check which of the following areas are of most concern to you:

- ○ Bags / swelling under eyes
- ○ Jowls
- ○ Wrinkles
  - ○ Nasolabial (nose to mouth)
  - ○ Eyes (crowsfeet)
  - ○ Lips
  - ○ Other _____
- ○ Premature graying of hair
- ○ Lusterless skin
- ○ Sun damage
- ○ Broken capillaries
- ○ Protruding temportal veins
- ○ Sagging face
- ○ Vertical creases / furows
- ○ Acne
- ○ Rosacea
- ○ Large pores
- ○ Droopy eyelids
- ○ Dry skin
- ○ Age spots
- ○ Double chin
- ○ Acne scarring

Please describe what your main skin complaint is if it's not listed above. _____

_____

_____

What improvements would you like to see? _____

_____

_____

_____

Please describe any skin sensitivities or allergies? _____

_____

_____

_____

Please describe any other skin conditions/issues you have. _____

_____

_____

_____

Please describe your current skin care regimen and products that you use (Toner, astringent, exfoliation, masks, etc).

_____

_____

_____

Do you wear makeup daily? ○ Yes ○ No Do you wear sunscreen daily? ○ Yes ○ No

What procedures have you had or are you currently undergoing?

- ○ Botox injections Dates:(s): _____
- ○ Collagen injections Dates:(s): _____
- ○ Restalyn Dates:(s): _____
- ○ Silacon injections Dates:(s): _____
- ○ Mesotherapy Dates:(s): _____
- ○ Microdermabrasion Dates:(s): _____
- ○ Chemical peels Dates:(s): _____
- ○ Laser procedures Dates:(s): _____
- ○ Threading (Lift) Dates:(s): _____
- ○ Rhytidectomy Dates:(s): _____
- ○ Blepharoplasty Dates:(s): _____
- ○ Brow or Coronal lift Dates:(s): _____
- ○ Other _____

Dates:(s): _____