White Center Chiropractic

Date:_____

Confidential Patient Information (PLEASE PRINT)

_____ Marital Status S M D W

Last Name First Name Middle Name Nickname

_____

Address City State Zip Code

Home Phone: (_____)_____ Mobile Phone:(_____)_____ Work Phone:(_____)_____

What is the best number to contact you at?_____

Email Address: _____ Is it ok to contact you or send info by Email? _____

Employer: _____ Occupation: _____

Emergency Contact Name and Phone Number: _____

Social Security Number: _____-_____-_____ Date of Birth:_____/_____/_____

Insurance Company and Policy #:_____*Please show ins. card to receptionist

How did you hear about our office?_____

Symptoms

What do you believe caused your problem? (i.e.- work injury, auto injury, other injury, illness, etc.) ?

_____

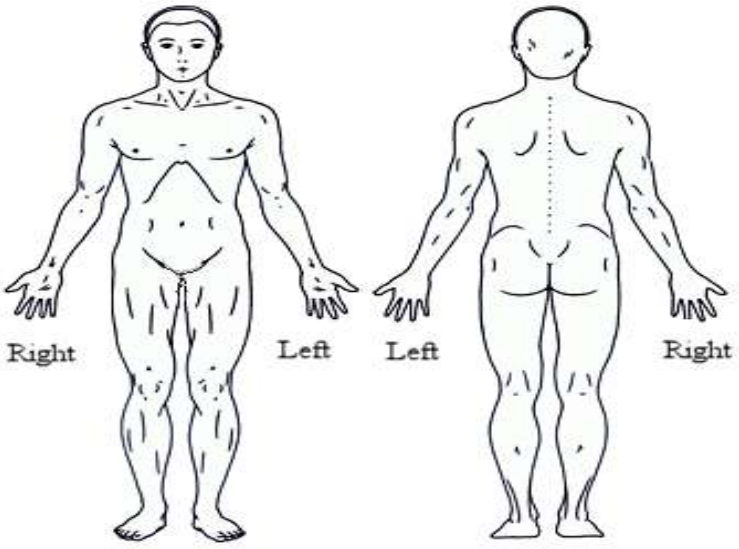
Who have you seen for this problem? Chiropractor? _____ Medical Doctor? _____

Results of care for this problem?_____

What is the **<u>one area</u>** of most pain or concern **(1st problem)**?_____

What is the **<u>second area</u>** of pain or concern **(2nd problem)**?_____

Any other pain, symptoms, or concerns?_____



<u>Please mark the appropriate symbols on the figures depending on the type of pain or problem.</u>

Numbness	**= = =**
Dull Ache	**OOO**
Burning	**XXX**
Sharp/Stabbing	**/ / /**
Pins/Needles	**+ + +**
Stiff/Tight/Pressure	**^^^**
Other _____	**???**

Past Medical History

Who is your primary care physician?_____ **List any Allergies:**_____

Have you had any previous injuries? No Car Accident Work Injury Sports Injury Other: _____

If applicable, when did the injury occur? And details._____

List any hospitalizations with reason and date?_____ _____

List any surgeries and dates:_____ _____

Please list all medications/supplements you are taking:_____

General Activities (Please answer/circle all that apply)

Member of Health Club Lift Weights Aerobic Exercise Sports Played:_____

Exercise _____days per week Sleep on stomach Sleep with 2+ pillows Read in Bed Play Video Games Smoker

Use Computer _____ hours per day Watch Television _____ hours per day Drive _____hours per day

Review of Symptoms: **Please <u>circle</u> any symptoms/conditions you have had in the <u>recent past or presently have</u>**

A - General Fatigue Weakness Fever (continuous) Loss of Sleep Chills (continuous) Weight Change Night Sweats

B – Headaches Dizziness Fainting Convulsions Nervousness

C – Anxiety Depression Phobias/excessive fears Memory Loss or Impairment Mood Swings

D – Hearing Trouble Ringing in Ears Pain in Ears Ear Discharge Vision Trouble Pain in Eyes Eye Discharge

E – Nose/Sinus Pain Excessive Drainage Nose Bleeds (chronic) Nasal Infections (chronic) Absence of Smell

F – Mouth Sores Bleeding Gums Enlarged Glands Abnormal Taste Sensations Tonsillitis Difficulty Swallowing

G – Heat/Cold Intolerance Goiter (enlarged thyroid gland) Tremors (shaking)

H – Skin Rash Redness of Skin Skin Itching Skin Dryness Scaly Skin Hair Changes Nail Changes Bruise Easily

I – Chronic Cough Chronic Wheezing Difficulty Breathing Swollen Extremities Blue Extremities Visible Veins
Rapid Heart Beat Chest Pain Heart Palpitations Heart Murmur

J – Decreased Appetite Increased Appetite Abdominal Pain Hemorrhoids Excessive Gas Vomiting (excessive)
Diarrhea (excessive) Constipation (excessive) Heartburn/Indigestion Numbness in groin

K – Prostate problems Painful Urination Frequent Urination Inability to Hold Urine Bed Wetting Irregular Periods

L – Impotence Lump in Breast Redness/Itching of Breast Dimpling of Breast Discharge from Breast Breast Pain

M – Rheumatoid Arthritis Osteoarthritis Other Rheumatic Disorder Diabetes Cancer Heart Attack Stroke

AIDS Epilepsy Tuberculosis Osteoporosis Other:_____

I certify that I understand the above information or I will ask for clarification. The above information is accurately answered. I authorize the performance of chiropractic examination, x-rays, adjustments, and other treatment if deemed necessary. I understand that as with any medical treatment there are risks and I will be given the opportunity to ask questions before any procedure is performed. I will ask questions or ask the doctor to address any concerns prior to performance of any service. I authorize this office to release any information regarding my or my child's care to 3rd party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature: _____ Date:_____