Snohomish Chiropractic & Nutrition

1405 Avenue D, Snohomish, WA 98290, 360-863-3949
www.snohochiro.com

About You:

Today's Date:_____ Soc Sec#:_____

Last Name: _____

First Name:_____M.I.____

Mailing Address:_____

City:_____State_____

Zip_____DOB: __/__/___ Age: _____

Race:_____Language:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____Carrier_____

Email:_____

What's best way to contact you? □Home Phone □ Work Phone

□ Cell Phone (Voice) □Cell Phone (Text) □ E-Mail

Referred By:_____

Occupation:_____

Since: _____/_____/_____ (Date)

Status: □ Single □ Married □ Divorced □Widowed

Spouse's Name:_____

Children: □ No □Yes How Many? _____

Children's Names:

_____ _____

_____ _____

Chiropractic History:

Have you had Chiropractic Care before? □ Yes □No

If yes, please explain the reason for the visits, and your experience:

_____

_____

_____

_____

Doctor's Name:_____

Approx. Date of last visit _____/_____/_____

Would you like us to contact them regarding your care?

□ Yes □No Phone number:_____

Physicians:

Primary Physician:

Name:_____

Address:_____

City:_____State:___Zip:_____

Phone:_____

Type of Physician:_____

Other Physicians:

Name:_____

Address:_____

City:_____State:___Zip:_____

Phone:_____

Type of Physician:_____

Name:_____

Address:_____

City:_____State:___Zip:_____

Phone:_____

Type of Physician:_____

Name:_____

Address:_____

City:_____State:___Zip:_____

Phone:_____

Type of Physician:_____

Emergency Contact:

In the event of an emergency, who should we contact?

Name:_____

Relationship:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

PLEASE CONTINUE ON OTHER SIDE

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Health History:

Are you currently taking any medications or supplements?

Medication/Supplement	Dosage/Frq	Medication/Supplement	Dosage/Frq

Please check the box next to any condition you have <u>OR HAVE HAD IN THE PAST</u>:

	Condition	Date Diagnosed		Condition	Date Diagnosed
☐	Severe or frequent Headaches		☐	Diabetes	
☐	Frequent Neck Pain		☐	Digestive Problems	
☐	Pain Between the Shoulders		☐	Loss of Sleep	
☐	Numbness/Pain in the Arms/Legs		☐	Psychiatric Problems	
☐	Low Back Pain		☐	Seizures/Epilepsy	
☐	Respiratory Problems		☐	High/Low Blood Pressure (circle one)	
☐	Congenital Heart Defect		☐	Sinus Problems	
☐	Heart Murmur or Arrhthmia		☐	Dizziness	
☐	Ulcers/Colitis		☐	Stroke	
☐	Kidney Problems		☐	HIV/Aids	
☐	Tuberculosis		☐	Anemia	
☐	Alcohol/Drug Abuse		☐	Heart Attach/Disease/Congestive Failure	
☐	Rheumatic Fever		☐	Asthma	
☐	Emphysema		☐	Cancer	
☐	Artificial Bones/Joints/Implants		☐	Hepatits Type:_____	
☐	Thyroid Disease		☐	Arthritis Type:_____	
☐	Glaucoma		☐	Cataracts	

Please List Any Additional Illnesses:

Illness	Date	Illness	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Please List Any Allergies you have:

Allergy	Date of last episode	Reaction

Please List Any Surgeries you've had:

Surgery	Date	Results

Alocohol Use:_____(drinks/day) **Caffeine Use:**_____(drinks/day) Exercise: _____ (Frequency)
Drug Use – Recreational □ Addiction □ □ Daily, □ Weekly
Do You Smoke? □ YES Packs/Day:_____ □ FORMER SMOKER □ NO
Are you wearing: □ Shoe Lifts □ Inner Soles □ Arch Supports or Orthotics □ Heel Lifts
If you checked any of the above – when did you start wearing them (approximate date): _____
When they were last checked for fit (approximate date): _____

Women Only: Are you taking Birth Control? □ Yes □ No Are you Nursing? □ Yes □ No
Are you Pregnant? □ Yes □ No If yes, how many weeks?_____ Do you experience painful periods? □ Yes □ No
Do you experience Irregular Cycles? □ Yes □ No Are you Breast Feeding? □ Yes □ No

Family History:

Family History: (please be specific – e.g. Maternal Grandmother) - Include Grandparents, Parents and Siblings.

Family Member	Disease	Deceased? (Y/N)

PLEASE CONTINUE ON OTHER SIDE

Current Problem List:

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Symptom #1:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Frequency: _____% (% of waking hours)

Symptom #2:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Frequency: _____% (% of waking hours)

Symptom #3:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Frequency: _____% (% of waking hours)

Symptom #4:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Frequency: _____% (% of waking hours)

Symptom #5:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Frequency: _____% (% of waking hours)

Symptom #6:_____ □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Frequency: _____% (% of waking hours)

When did your symptoms begin?_____

What was the cause of your symptoms? □Auto Accident □Work Injury □Lifting □Slip/Fall □Overexertion

□Strenuous Position □Unknown □Other_____

Approximate Onset Date:_____ □Gradual Onset □Sudden Onset

Work

How do your health problems make it harder to do your job?_____

_____

Are you less productive on your job because of your health problems? □Yes □No

Are you concerned about your ability to do your job or the security of your job? □Yes □No

Please Explain_____

Social/Recreational

Have you had to modify your lifestyle in anyway due to this condition?

_____

_____

Authorization For Care:

I hereby authorize the Doctor and appointed staff to work with my condition through the use of chiropractic care, rehabilitation, nutrition, and other modalities agreed upon as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand payment in full for all services rendered is required in full at the time of service unless other arrangements have been made in advance. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I authorize the provider to release any information required to process insurance claims. I hereby authorize assignment of my insurance rights and benefits (if using insurance) directly to the provider for services rendered.

_____ _____

Patient's Signature Date Guardian or spouse's signature authorizing care Date

Insured Person:_____ **Relationship:**_____

Employer:_____ **DOB:** _____