



1601-A William Way, Mount Vernon, WA 98273 • 360-424-8115

New Patient Form – Please fill out completely and clearly. Don't hesitate to ask for help if you have any questions. Also, please make sure to print your name and date the bottom left corner of each page.

Personal Information

Name: _____
Street Address: _____
City/State/Zip: _____
E-Mail Address: _____
(H) Phone: (_____) _____ - _____ (W) Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
Birthdate: _____ / _____ / _____ Age: _____ Sex: M ___ F ___
Social Security #: _____ *

*This will only be used for processing insurance claims and will be kept secure, confidential, and compliant with HIPPA privacy standards.

Name of Employer: _____ Occupation: _____
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
Name of Spouse/Significant other (if applicable): _____
Name of Spouse/Significant other employer: _____
Work phone: (_____) _____ - _____ Cell phone: (_____) _____ - _____
Children: Yes ___ No ___ If yes, how many: _____
Who referred you to our office: _____

Emergency Contact Information

Name: _____ Relation: _____
Day Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Insurance Information

Do you have insurance? Yes No Is there a secondary insurance? Yes No

Primary Insurance:

Insurance Company: _____
Member Name: _____ Identification #: _____
Policy/Group #: _____ Employer: _____

Secondary Insurance:

Insurance Company: _____
Member Name: _____ Identification #: _____
Policy/Group #: _____ Employer: _____

Print Name: _____
Date: _____

Current Condition

1. What is your primary complaint or reason for seeking care in our office? _____
2. When did you first start to notice the onset of symptoms related to this condition?

a. How did it occur? _____
b. Has your condition gradually been getting better, worse, or staying the same? _____
3. If this is a recurrence of a chronic condition, when was the first time you experienced this problem? _____
4. How does your primary complaint interfere with your daily life or the activities you enjoy (i.e. work, exercise, getting dressed, social life, sleep, etc.)? _____
5. How would you best describe the symptoms you are experiencing? (i.e. burning, stabbing, numbness, tingling, dull ache, sharp, etc.) _____
6. How frequent is this condition? _____ < 25% of day
_____ 26-50% of day _____ 51-75% of day
_____ 76-100% of day _____ Only at night
7. How long does it last?
_____ A few Seconds _____ A few hours
_____ A few minutes _____ All night
_____ All day
8. What makes it Better? _____
9. What makes it Worse? _____
10. Have you seen any other health professional for this condition? _____
If so, who? _____
11. Have you had any testing or imaging performed related to this condition (i.e. MRI, CT, X-Ray, etc.)? If so, when? _____
12. Have you had Chiropractic Care before? If yes: when, where, with whom, and date of last visit: _____
13. Are there any other conditions or symptoms that may be related to your major symptom? If yes, what? _____
14. Have you ever been involved in an automobile collision or work related injury?
Within the past year _____ Past 5 years _____ Over 5 years _____ Never _____
15. What significant health problems have you had in the past? _____
16. What significant accidents, falls, or injuries have you had in the past? _____
17. Please list all surgeries you have had including date: _____

Print Name: _____
Date: _____

Symptom Diagram

Symptom Pattern Diagram

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache >>>>

Numbness =====

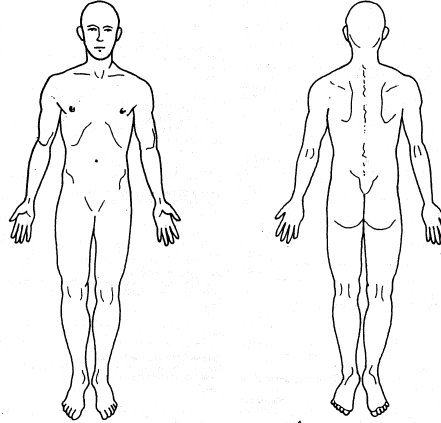
Pins & Needles o o o o

Burning x x x x

Stabbing / / / /

Throbbing ~ ~ ~ ~ ~

Other: #####



Your Habits

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruits/Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fast Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Miscellaneous

Drugs or Medication(s) you take:

Sleeping Pills Antidepressants Blood Pressure Cholesterol

Birth Control Other: _____

Do you take nutritional Supplements? If so, please list: _____

Age of Mattress: _____ Comfortable Uncomfortable

Are you wearing: Heel Lifts Sole Lifts Arch Support/Orthotic

Health History

Please indicate for each of the questions below your experience by use of the following code: 1 = Presently have, 2 = Previously had

Musculo-Skeletal System

___ Lower Back Problems	___ Middle Back Pain	___ Neck Problems
___ Arm Problems	___ Leg Problems	___ Swollen Joints
___ Painful Joints	___ Stiff Joints	___ Sore Muscles
___ Weak Muscles	___ Walking Problems	___ Herniated Disk
___ Hernia	___ Broken Bones	___ Teeth Grinding

Print Name: _____

Date: _____

Health History - Continued

Genito-Urinary System

- | | | |
|--|--|--|
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Scanty Urination |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Hard to Start Urination |
| <input type="checkbox"/> Testicular Pain | <input type="checkbox"/> Painful Ejaculation | <input type="checkbox"/> STD |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Urinary Tract Infection |

Gastro-Intestinal System

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloody Stool | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Weight Trouble | <input type="checkbox"/> Heart Burn |

Nervous System

- | | | |
|--|--|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Loss of Feeling | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Muscle Twitch/Spasm | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Pain Down Legs/Arms |

Eye, Ear, Nose, & Throat

- | | | |
|--|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Eye Inflammation | <input type="checkbox"/> Ear Discharge |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Nose Pain | <input type="checkbox"/> Nose Bleeding | <input type="checkbox"/> Nose Discharge |
| <input type="checkbox"/> Sore Gums | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Sore Throat |

Female

- | | | |
|--|---|---|
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Vaginal Pain |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Lumps on Breast | <input type="checkbox"/> Painful Menstruation |

Cardiovascular & Respiratory Systems

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Blood Pressure Problem |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Varicose Veins |

Family History

Please circle all that apply:

- Grandparents: Heart Disease Cancer Stroke Diabetes High blood pressure Other: _____
- Father: Heart Disease Cancer Stroke Diabetes High blood pressure Other: _____
- Mother: Heart Disease Cancer Stroke Diabetes High blood pressure Other: _____
- Siblings: Heart Disease Cancer Stroke Diabetes High blood pressure Other: _____

Additional notes on family history: _____

Print Name: _____

Date: _____

Consent to X-Ray – Female Patients and Children under the age of 18

This is to certify that to the best of my knowledge I am not pregnant and that Northwest Chiropractic, PS has my permission to take x-rays of me.

Patient Signature: _____

Today's Date: _____ Date of Last Menses: _____

I hereby give my consent to Northwest Chiropractic, PS to examine, x-ray, and treat my child of ward.

Patient's Name: _____

Guardian's Signature: _____ Date: _____

Treatment

What Type of treatment are you looking for?

- I am looking for the most minimal amount of care to find relief of the symptoms I am experiencing.
- I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
- I am looking to take care of my problem and then go on to "performance and wellness care" to achieve my optimal level of health.

Please list any other treatment/health goals so that we can work together to best achieve your objective for seeking care at our office:

Patient Agreement

Reminder: Your insurance is an agreement between you and your insurance. You must clearly understand and agree that for all services rendered to you in our office, you will be charged directly and you are personally responsible. As a courtesy to our patients, our office will submit your insurance claims in a timely manner at no charge to you.

By signing below, I permit Northwest Chiropractic, PS to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered are charged directly to my account and that I am personally responsible for payment. It is my understanding that if I suspend or terminate my care and treatment; any fees for professional services rendered will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors of Northwest Chiropractic, PS, and whomever they may designate as their assistants, to administer treatment as they so deem necessary. I also authorize the release of any information acquired in the course of my examination and treatment in accordance with HIPAA privacy regulations.

I understand that the above information and statements made on this form are accurate to the best of my knowledge, and I understand it is my responsibility to inform the office of any future changes in medical status.

Signature: _____ Date: _____

Parent or Guardian's Signature: _____

Print Name: _____

Date: _____