Today's Chiropractic Clinic, P.S.

"Gentle effective back and neck care for the active family"

614 South 225th, Des Moines, WA 98198 Telephone: 206-878-BACK (2225) Fax: 206-878-7488

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably we will not be able to accept your case. We will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely.

Date _____ **Social Security #** _____

Name _____ Home Phone _____

Street _____ City/State _____ Zip _____

Age _____ Birth Date _____ Marital Status S M W D E-mail _____

Occupation _____ Work # _____ Cell #_____ How many children _____

Employer _____ Address _____ Zip _____

Who can we thank for referring you into our office? _____

Purpose of this appointment _____ Previous chiropractic care/Where? _____

Name of Spouse _____ Occupation _____

Employer _____ Office Phone _____

Emergency Contact _____ Phone _____

PAYMENT IS EXPECTED AT TIME OF SERVICE. Person responsible for payment _____

Address (if different from above) _____

Relationship _____ Phone _____ Work Phone _____

Are You Insured? ☐ yes ☐ no : Insurance Company _____

Ins Co. Address _____ Phone _____

Policy # _____ Claim # _____ Group/Plan # _____

If not subscriber, give subscriber's name _____ SS # _____

Financial Responsibility Statement

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Today's Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Today's Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, against the Doctor's recommendation, my account balance will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian/Spouse Signature _____ Date _____

Driver's License # _____ Date Expires _____

Social Security # _____ Spouse's Social Security # _____

Complete the following for your top three complaints:

First Complaint: _____

When did it begin?: _____

Circle what makes it better: ice, heat, treatment, rest, stretching, other: _____

Circle what makes it worse: over exertion, sleep, standing, walking, other: _____

Circle Pain Intensity:
(no pain) (worst pain)
0 1 2 3 4 5 6 7 8 9 10

Circle Pain Frequency:
(never) (constant)
0 1 2 3 4 5 6 7 8 9 10

Second Complaint: _____

When did it begin?: _____

Circle what makes it better: ice, heat, treatment, rest, stretching, other: _____

Circle what makes it worse: over exertion, sleep, standing, walking, other: _____

Circle Pain Intensity:
(no pain) (worst pain)
0 1 2 3 4 5 6 7 8 9 10

Circle Pain Frequency:
(never) (constant)
0 1 2 3 4 5 6 7 8 9 10

Third Complaint: _____

When did it begin?: _____

Circle what makes it better: ice, heat, treatment, rest, stretching, other: _____

Circle what makes it worse: over exertion, sleep, standing, walking, other: _____

Circle Pain Intensity:
(no pain) (worst pain)
0 1 2 3 4 5 6 7 8 9 10

Circle Pain Frequency:
(never) (constant)
0 1 2 3 4 5 6 7 8 9 10

Are any of the above complaints due to an on-the-job or auto injury?
____YES ____NO

Environment - (Please circle appropriate answer):

Work:
Seated/Standing - Work bench / Desk / Counter / Other:_____

Job involves - Lifting / Bending / Stooping / Twisting /Carrying / Walking / Standing / Other: _____

Chair - Executive / Steno / Bench / Stool / Folding / Other: _____

Leisure:
List sedentary activities: _____

List strenuous activities: _____

List sporting activities: _____

Do you exert yourself? - Frequently / Occasionally / Rarely / Never?

"The nervous system controls and coordinates all organs and structures of the human body:" (Gray's Anatomy, 29th Ed.,page 4).

Please indicate your experience with each of the following by marking: 1 = presently have or 2 = previously had

Effects	Vertebrae
☐Headaches, ☐Nervousness, ☐Insomnia, ☐Head colds, ☐High blood pressure, ☐Migraine headaches, ☐Amnesia, ☐Chronic tiredness, ☐Dizziness	C-1
☐Sinus trouble, ☐Allergies, ☐Pain around the eyes, ☐Earache, ☐Fainting spells, ☐Ringing in the ears	C-2
☐Neuralgia, ☐Neuritis, ☐Acne or Pimples, ☐Eczema	C-3
☐Hay fever, ☐Runny Nose, ☐Hearing loss, ☐Adenoids	C-4
☐Laryngitis, ☐Hoarseness, ☐Other throat conditions	C-5
☐Stiff neck, ☐Pain in upper arm, ☐Tonsillitis, ☐Chronic cough, ☐Croup	C-6
☐Bursitis, ☐Colds, ☐Thyroid conditions	C-7
☐Asthma, ☐Cough, ☐Difficult breathing, ☐Shortness of breath, ☐Pain in lower arms and hands	T-1
☐Functional Heart Conditions, ☐Chest conditions	T-2
☐Bronchitis, ☐Pleurisy, ☐Pneumonia, ☐Congestion, ☐Influenza	T-3
☐Gall bladder conditions, ☐Jaundice, ☐Shingles	T-4
☐Liver conditions, ☐Fevers, ☐Blood pressure problems, ☐Poor circulation, ☐Arthritis	T-5
☐Stomach troubles, ☐Nervous stomach, ☐Indigestion, ☐Heartburn, ☐Dyspepsia	T-6
☐Ulcers, ☐Gastritis	T-7
☐Lowered resistance	T-8
☐Allergies, ☐Hives	T-9
☐Kidney trouble, ☐Hardening of the arteries, ☐Chronic tiredness, ☐Nephritis, ☐Pyelitis	T-10
☐Skin conditions, ☐Acne, ☐Eczema, ☐Boils	T-11
☐Rheumatism, ☐Gas pains, ☐Sterility	T-12
☐Constipation, ☐Colitis, ☐Dysentery, ☐Diarrhea, ☐Hernia trouble	L-1
☐Cramps, ☐Difficult breathing, ☐Varicose veins	L-2
☐Bladder trouble, ☐Menstrual troubles, ☐Irregular periods, ☐Miscarriages, ☐Bed wetting, ☐Impotency, ☐Menopause, ☐Knee pains	L-3
☐Sciatica, ☐Low back pain, ☐Difficult, painful urination ☐Frequent urination, ☐Backaches	L-4
☐Poor circulation in legs, ☐Swollen ankles, ☐Weak ankles and arches, ☐Cold feet, ☐Weakness in legs, ☐Leg cramps	L-5
☐Sacro-iliac conditions, ☐Spinal curvatures	SACRUM
☐Hemorrhoids (piles), ☐Pruritis (itching), ☐Pain on end of spine on sitting	COCCYX