



# 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 # \_\_\_\_\_

**List present complaints, injuries and duration:**

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_

**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 \_\_\_\_\_

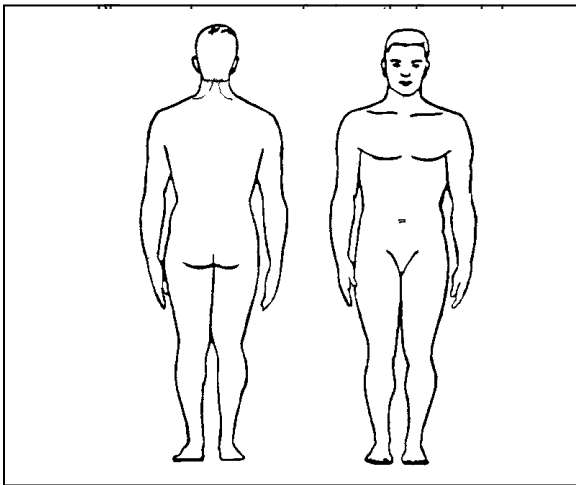
Leisure:

List sedentary activities \_\_\_\_\_

List strenuous activities \_\_\_\_\_

List sporting activities \_\_\_\_\_

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



Are any of the above complaints due to an on-the-job or auto injury? YES NO

**List other doctors consulted for present complaint/injuries:**

Name \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment \_\_\_\_\_

How long \_\_\_\_\_ How frequent \_\_\_\_\_

Results \_\_\_\_\_  
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Name \_\_\_\_\_ Date \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment \_\_\_\_\_

How long \_\_\_\_\_ How frequent \_\_\_\_\_

Results \_\_\_\_\_  
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**Present Family Doctor** \_\_\_\_\_

**Date of last physical examination** \_\_\_\_\_

By Doctor \_\_\_\_\_

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