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_____

BD _____/_____/_____ Identification #:_____ Group #_____

Employer_____

Print Name _____
Date _____

Current Condition

1. What are your primary complaints or reasons for seeking care in our office?
   1._____2._____
2. When did you first start to notice the onset of symptoms related to these conditions?
   1._____2._____
   a. How did it occur? 1._____
      2._____
   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? _____
7. When you experience the pain, how long does it last?
   _____ A few Seconds _____ A few minutes _____ A few hours
   _____ All day _____ All night
8. What makes it Better? _____
   _____
9. What makes it Worse? _____
   _____
10. Have you seen any other health professionals for this condition? _____Yes _____No
    If yes, who? _____
11. Have you had any testing or imaging performed related to this condition (MRI, CT, X-Ray, etc.)? If so, what and 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 ____ 5-10 years ____ Over 10 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 _____

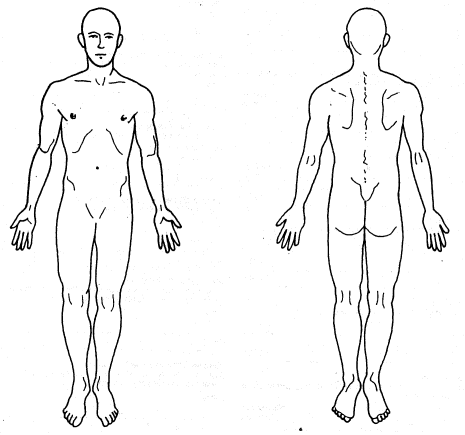
Symptom Diagram

Symptom Pattern Diagram

Please read carefully:

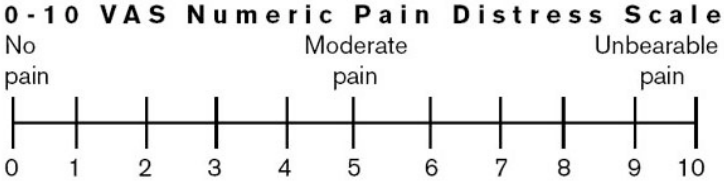
Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache - **A**
Numbness - **N**
Burning - **B**
Stabbing - **S**
Throbbing - **T**
Other: #



Using the scale to the right, grade your pain

Headache	_____
Neck pain	_____
Mid back pain	_____
Low back pain	_____
Arm/shoulder pain	_____
Leg pain	_____
Other_____	_____



Your Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Medication	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Fruits/Vegetables	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Stress	☐	☐	☐	☐

Sleep - Average hours per night_____

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

Print Name _____

Date _____

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

Genito-Urinary System

___Bladder Trouble	___Excessive Urination	___Scanty Urination
___Painful Urination	___Discolored Urine	___Hard to Start Urination
___Testicular Pain	___Painful Ejaculation	___STD
___Kidney Stones	___Kidney Disease	___Urinary Tract Infection

Gastro-Intestinal System

___Poor Appetite	___Excessive Hunger	___Difficulty Swallowing
___Excessive Thirst	___Nausea	___Vomiting
___Abdominal Pain	___Diarrhea	___Constipation
___Bloody Stool	___Hemorrhoids	___Liver Trouble
___Gall Bladder Problems	___Weight Trouble	___Heart Burn

Nervous System

___Numbness	___Loss of Feeling	___Paralysis
___Dizziness	___Fainting	___Headaches
___Muscle Twitch/Spasm	___Concussion	___Depression
___Seizures	___Tingling in Hands	___Pain Down Legs/Arms

Eye, Ear, Nose, &Throat

___Vision Problems	___Eye Inflammation	___Ear Discharge
___Ear Pain	___Ear Ringing	___Hearing Loss
___Nose Pain	___Nose Bleeding	___Nose Discharge
___Sore Gums	___Dental Problems	___Sore Throat

Female

___Vaginal Discharge	___Vaginal Bleeding	___Vaginal Pain
___Breast Pain	___Lumps on Breast	___Painful Menstruation

Cardiovascular & Respiratory Systems

___Chest Pain	___Difficulty Breathing	___Persistent Cough
___Coughing Blood	___Rapid Heartbeat	___Blood Pressure Problem
___Heart Problems	___Lung Problems	___Varicose Veins

Print Name _____

Date _____

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: _____

_____

_____

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 _____