The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

Date _____

Name _____ Soc. Sec. No. _____ Home Phone _____

Cell ph# _____ Pager# _____ Fax# _____

Address _____ City _____ Zip Code _____

Age _____ Birth date _____ Marital: M S W D How many children?_____

Occupation _____ Employer _____ Work Phone_____

Spouse's name_____ Spouse's birthday_____Spouse's Soc. Sec. No. _____

Spouse's employer _____ Work phone _____

Insured 's name if patient is a dependent _____ Soc. Sec. No. _____

Insured 's employer _____ Work phone_____

Brief Job Description _____

Patient's nearest relative(not living with you)_____Address _____ Phone _____

Who referred you to our office? _____

Please state your health problems in order of severity:

* Describe their **SEVERITY** on a scale from 0 to 10, with 0 being No Pain and 10 being the worst pain you have ever experienced
* Describe the **CHARACTER** of your pain, i.e., constant, burning, sharp, dull stabbing, throbbing, etc.
* **HOW LONG** have you had each problem?

Problem (s)	Severity	Character	How long?
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____

What do you expect to gain from initiating Chiropractic care?

_____

_____

Is your current condition the result of an accident? ☐ Yes ☐ No

If yes, ☐ Work related ☐ Auto accident ☐ Other _____

Date of injury? _____

What days have you lost from work? _____

Is this condition getting progressively worse ? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you had a similar condition berfore? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other

_____

How long has it been since you really felt good? _____

Sleeping position: ☐ Stomach ☐ Side ☐ Back

Have you seen other Doctors for this condition ☐ Yes ☐ No

If yes, please list: _____

If yes, did your condition ☐ Totally Improve ☐ Partially Improve ☐ Worsen ☐ Remain the same

What do you believe is wrong with you? _____

What operations have you had? _____

Describe: _____

Are you pregnant? ☐ Yes ☐ No Date of onset last menstrual cycle? _____

Please check the appropriate box for any of the following symptoms you are now experiencing or have had previously.

Fitzpatrick Chiropractic Clinic
65 Rainer Blvd. N. • P.O. Box 658
Issaquah, Washington 90827
(425) 392-5321

THIS IS A CONFIDENTIAL HEALTH REPORT

KEY

O Occasional
F Frequent
C Constant

O	F	C	GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Headache
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Back pain (lower)
☐ ☐ ☐ Back pain (upper)
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Neck pain/stiffness
☐ ☐ ☐ Pain between shoulders
☐ ☐ ☐ Shoulder pain/numbness
☐ ☐ ☐ Arm pain/numbness
☐ ☐ ☐ Elbow pain/numbness
☐ ☐ ☐ Hand, wrist pain/numbness
☐ ☐ ☐ Hip pain/numbness
☐ ☐ ☐ Leg pain/numbness
☐ ☐ ☐ Knee pain/numbness
☐ ☐ ☐ Foot, Ankle pain/numbness
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Swollen joints

O	F	C	GASTRO-INTESTINAL
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Distension of abdomen
☐	☐	☐	Gallbladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Liver trouble
☐	☐	☐	Stomach pain

EYES/EARS/NOSE THROAT

☐ ☐ ☐ Asthma
☐ ☐ ☐ Colds
☐ ☐ ☐ Deafness
☐ ☐ ☐ Earache
☐ ☐ ☐ Ear discharge
☐ ☐ ☐ Ear noise
☐ ☐ ☐ Eye pain
☐ ☐ ☐ Nasal obstruction
☐ ☐ ☐ Nosebleeds
☐ ☐ ☐ Sinus infection

CARDIO-VASCULAR

☐ ☐ ☐ Hardening of arteries
☐ ☐ ☐ High blood pressure
☐ ☐ ☐ Low blood pressure
☐ ☐ ☐ Pain over heart
☐ ☐ ☐ Poor circulation
☐ ☐ ☐ Rapid heart beat
☐ ☐ ☐ Slow heart beat
☐ ☐ ☐ Swelling of ankles

O	F	C	RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

SKIN

☐ ☐ ☐ Bruise easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Eruptions/rash
☐ ☐ ☐ Varicose veins

GENITO-URINARY

☐ ☐ ☐ Bed-wetting
☐ ☐ ☐ Bladder problems
☐ ☐ ☐ Blood in urine
☐ ☐ ☐ Frequent urination
☐ ☐ ☐ Kidney problems
☐ ☐ ☐ Painful urination
☐ ☐ ☐ Prostrate problems
☐ ☐ ☐ Pus in urine

FOR WOMEN ONLY

☐ ☐ ☐ Breast problems
☐ ☐ ☐ Cramps or backache
☐ ☐ ☐ Menstrual problems
☐ ☐ ☐ Hot flashes
☐ ☐ ☐ Irregular cycle
☐ ☐ ☐ PMS syndrome
☐ ☐ ☐ Menopausal symptoms
☐ ☐ ☐ Vaginal problems

Drugs/Medications you are presently taking:

☐ Nerve Pills
☐ Muscle relaxers
☐ Tranquilizers
☐ Diuretics
☐ Other: _____

☐ Pain killers
☐ "PEP" pills
☐ Insulin
☐ Birth control pills

Date of last:

Physical Exam _____
Spinal Exam _____
Spinal X-ray _____
Chest X-ray _____
Blood test _____
Urine test _____

Are you Insured? ☐ Yes ☐ No Insurance company: _____

Name of person responsible for payment? _____

How do you intend to pay for today's visit? ☐ Cash ☐ Check ☐ Credit Card?

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's signature _____ Date _____

Guardian or spouse's signature authorizing care _____ Date