Bonney Lake Chiropractic

Scott A. Sheridan

9925 214th Ave. E. Ste. C
Bonney Lake, WA 98390
253-862-6662

Confidential Health History

Name________________________________ Occupation____________________________

Please Print

How long have you had this present pain? ________Hours ________Days ________Weeks ________Months

Where were you when this condition started? ☐At work ☐At home ☐Auto accident ☐ Other____________

Did your pain begin gradually? ☐Yes ☐ No Suddenly? ☐Yes ☐No Date ________ Time____________

Is your pain ☐continuous ☐off and on ☐getting progressively worse ?

Have you had this or similar condition before? ☐ Yes ☐ No If yes, when? ____________________

How long have you been off work or unable to do normal housework? ________________________

Have you ever been in the hospital for ☐ back ☐neck ☐leg problems? When____________________

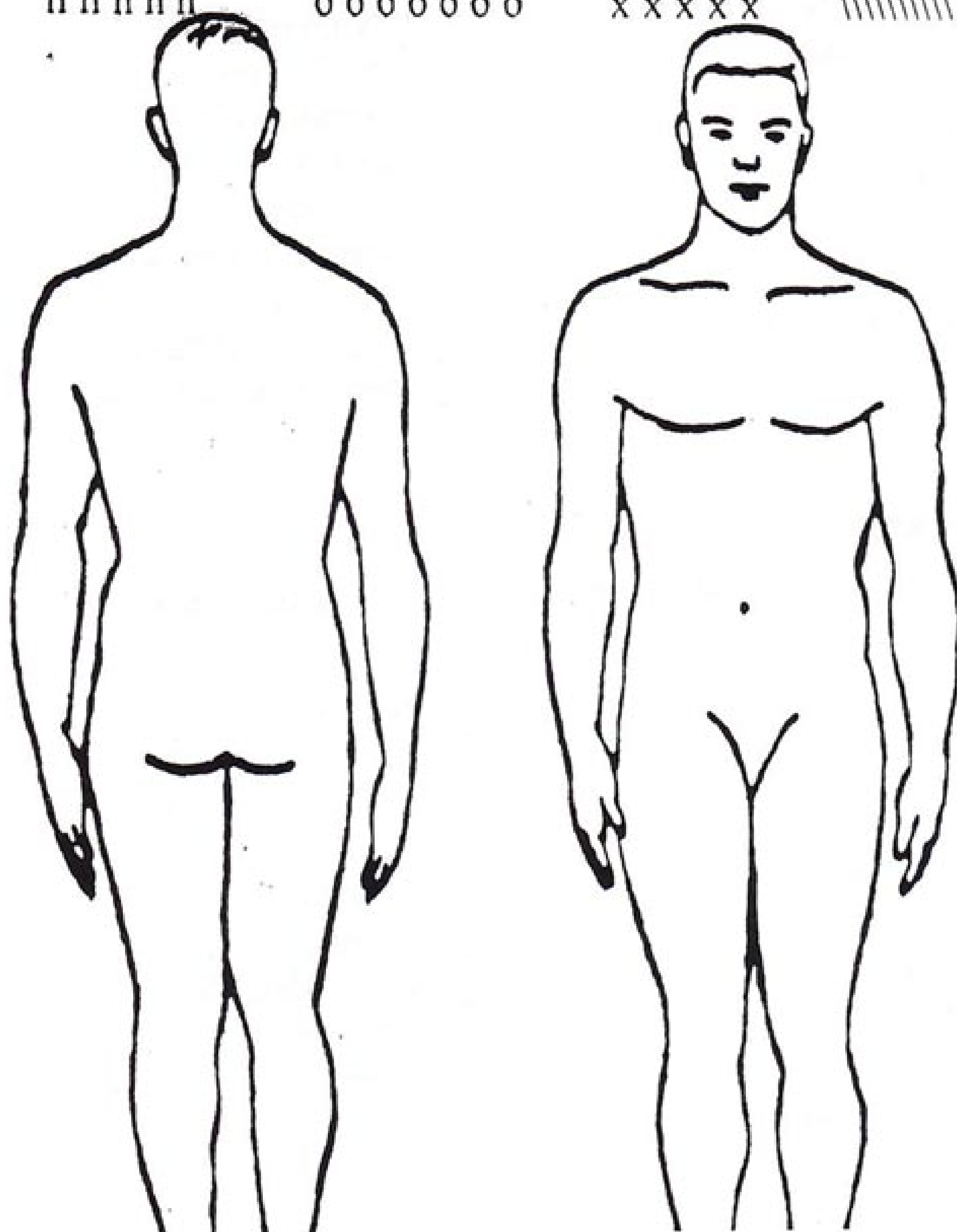
Have you ever had back or neck surgery? ☐Yes ☐No If yes, when?________________________

Name of doctors______________________________ Results________________________

Have any treatments made your pain worse? ☐ Yes ☐No What treatments?____________________

Mark the areas on the figures below where you feel the described sensations with the appropriate symbols.

Numbness	Pins & Needles	Burning	Stabbing
n n n n n	0 0 0 0 0 0 0	x x x x x	\\\\\\\\\\
n n n n n	0 0 0 0 0 0 0	x x x x x	\\\\\\\\\\



My pain is

Better	Worse	Unchanged	
☐	☐	☐	With coughing or sneezing
☐	☐	☐	Sitting down at table
☐	☐	☐	Sitting in an automobile
☐	☐	☐	Bending forward to brush teeth
☐	☐	☐	Walking for a short distance
☐	☐	☐	Lying flat on back
☐	☐	☐	Lying on side with knees bent
☐	☐	☐	When I wake in the morning
☐	☐	☐	Mid morning
☐	☐	☐	Middle of the night

My back sometimes gets "stuck" when I bend forward. ☐ Yes ☐ No

My back feels it is likely to give way on bending forward. ☐ Yes ☐ No

My pain stops after I walk a certain distance. ☐ Yes ☐ No

After walking, bending forward improves my pain. ☐ Yes ☐ No

Date:________________________

Signature:____________________________

Why are you seeing the doctor? ______________

____

This is a new/old illness? It was not/was treated before. If treated before, what was done? ________

____

When?______________ By whom?____________

Have you been X-Rayed before? What parts?

____

Pap smear (women only) Never ☐ Date _______
Prostate exam (men only) Never ☐ Date _______
Last medical examination Never ☐ Date _______

Who is/was your medical doctor?

____

Location?______________________

May we send your MD a report of your condition and progress? **Check one** ☐Yes ☐ No

Are you taking any medications? Specify.

____

Do you exercise regularly? Please explain. _____

____

Have you ever been hospitalized? For what?

____

Please indicate if you are having any of the following:

General Symptoms
___Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or Pain in arms/hands
___ Allergy
___ Wheezing
___ Neuralgia

Gastro-Intestinal
___Poor Appetite
___Poor Digestion
___Excessive Hunger
___Belching or Gas
___Nausea
___Vomiting
___Vomiting Blood
___ Pain over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids (Piles)
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble

Eye Ear Nose Throat
___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharge
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throat
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

Respiratory
___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

Genito-Urinary
___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Can't Control Urine
___ Prostate Trouble

Muscle & Joints
___ Weakness
___ Twitching
___ Stiff Neck
___ Backache
___ Swollen Joints
___ Tremors
___ Foot Troubles
___ Pain in Tail Bone
___ Pain Between Shoulders

Cardio-Vascular
___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Pain Over Heart
___ Pre. Heart Trouble
___ Swelling of Ankles
___ Poor Circulation
___ Varicose Veins

Skin or Allergies
___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives or Allergies
___ Eczema

For Women Only
___ Painful Periods
___ Excessive Flow
___ Irregular Cycles
___ Hot Flashes
___ Cramps or Backaches
___ Miscarriage
___ Vaginal Discharge
___ Pregnant at this time

Habits
___ Smoking packs per day
___ Alcohol glasses per day
___ Coffee cups per day

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sister # of ___	☐	☐	☐	☐	☐
Brother # of ___	☐	☐	☐	☐	☐

Have you had any of the following diseases?
___ Appendicitis
___ Pneumonia
___ Rheumatic Fever
___ Polio
___ Tuberculosis
___ Whooping Cough
___ Anemia
___ Measles
___ Mumps
___ Chicken Pox
___ Diabetes
___ Cancer
___ Heart Disease
___ Goiter
___ Influenza
___ Pleurisy
___ Alcoholism
___ Venereal Infection
___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Lumbago
___ Eczema

Bonney Lake Chiroprac

Scott Sheridan, DC

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Confidential Case History

Today's Date:	Referred By:		
Name:	Sex: M F	Birth Date	Age:
Person Responsible for Account (if minor):	Relationship to Patient:		
Mailing Address:	City:	State:	Zip:
Email Address:			
Home #:	Cell Phone #:		
Occupation:	Employer:		Work #:
Marital Status: M S W D	Weight:	Height:	
Spouse's Name:	Spouse's occupation:		Spouse's Work #:
Name/Phone # of nearest relative *not* living with you:			

Financial Agreement

Thank you for choosing us as your health care provider. We are committed to your treatment being successful Please understand that payment of your bill is considered a part of your treatment The following is a statement of our Financial Policy, which we require you to read and sign.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are ultimately responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. I understand health and accident insurance policies are an arrangement between the insurance company and myself, this office will prepare any necessary reports and forms for the insurance company As a courtesy Bonney Lake Chiropractic will also submit all claims to my insurance company. I hereby authorize the release of all informaton necessary to secure the payment of benefits I agree that any amount authorized to be paid for given services is to be paid directly to the doctor's office However, I clearly understand and agree that all services rendered to me will be immediately due and payable within 30 days All co-pays. deductibles, and cash pay visits are due at the time of service or a $5.00 charge will be added to my account I understand a $5 00 rebilling/late fee *may* be charged to my account if partial or no payment is made and a $25 00 fee will be added for returned checks We reserve the right to charge interest in the amount of 1% per month (12% per year) as provided by state law I am also aware that there will be a $25 00 service charge for any returned checks.

I hereby authorize Dr. Sheridan to treat my condition as he deems appropriate through the use of manipulation throughout my spine It is understood and agreed the amount paid to the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of Bonney Lake Chiropractic

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns I have read the Financial Policy. I understand and agree to this Financial Policy

Sign: ______________________ Print: ______________________ Date: __________

Patients Social Security Number: ______________________

Guardian's signature: ______________________ Date: __________