NEW PATIENT INFORMATION FORM

PUYALLUP CHIROPRACTIC CLINIC

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PATIENT INFORMATION

Date _____

Patient _____
First Middle Initial Last

Address _____ Apt. #

_____
City State Zip

Email Address _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Patient Social Security # _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Cell _____

Home _____ Work _____ Ext _____

Do you want appointment reminders via text message? ☐ Yes ☐ No

If yes, phone carrier? _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____

PRIMARY INSURANCE

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insurance Co. _____

Member # _____ Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co. _____

Member # _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other _____

Attorney Name (if applicable) _____

In the past 2 years have you opened a claim for a Labor and Industries injury, car accident or other personal injury? ☐ Yes ☐ No

If yes, ☐ Automobile ☐ L&I Date of incident _____

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

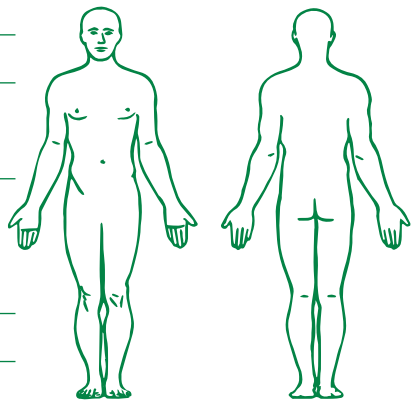
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Mark an X on the picture where you continue to have pain, numbness, or tingling.

– OVER –

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Others _____	
Cancer	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking
☐ Alcohol
☐ High Stress Level

Packs / Day _____

Drinks / Week _____

Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

INJURIES / SURGERIES YOU HAVE HAD	DESCRIPTION	DATE
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS / HERBS / MINERALS

SIGNATURE OF PATIENT / GUARDIAN: _____ **DATE:** _____