RAINIER VALLEY CHIROPRACTIC P.S.
David A. Butters D.C. — Natasha Butters D.C.
4236 36th Avenue S. Seattle, WA 98118
Phone 206-723-2820 Fax 206-722-3664

Patient Health History

Full Name____ Date____________________

Street Address____

City & State______________________________ Zip ____________

Phone Number ____________________Gender__________ Date of Birth______________ Age_____

SSN_________________________ How did you hear about our office? _________________________

Marital Status_____________________ # of Children? ____ Currently Pregnant? / How Long? __________

Occupation____________________________ Employer___________________________________

Place of Business Address____ Phone______________

Are you insured? ❑Yes ❑No Name of Insurance Company_____________________________________

Today's Major Complaints

Please check ✓ — ***Please*** (Circle) ***Your Level of Pain.***

Area of Pain and Type of Pain							***0= No Pain through 10=Extreme Pain***
❑Headache	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Neck Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Shoulder Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Arm Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Mid Back Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Low Back Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Hip Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Leg Pain	❑Lt	❑Rt	❑Ache	❑Dull	❑Sharp	❑Stabbing	0 1 2 3 4 5 6 7 8 9 10
❑Other ______________________							0 1 2 3 4 5 6 7 8 9 10
❑Other ______________________							0 1 2 3 4 5 6 7 8 9 10

I feel more pain when doing the following activities:

Check ✓ the activities that cause pain and then (Circle) minimal, mild, moderate or severe.

❑Sleeping	Minimal	Mild	Moderate	Severe
❑Sitting	Minimal	Mild	Moderate	Severe
❑Walking	Minimal	Mild	Moderate	Severe
❑Standing	Minimal	Mild	Moderate	Severe
❑Lifting	Minimal	Mild	Moderate	Severe
❑Household Chores	Minimal	Mild	Moderate	Severe
❑Routine Personal Care	Minimal	Mild	Moderate	Severe
❑Other ____________	Minimal	Mild	Moderate	Severe
❑Other ____________	Minimal	Mild	Moderate	Severe

Is your condition due to a work injury or automobile collision? **❑Yes** **❑No**
(***If yes, then please alert the front desk assistant. You will have some additional paperwork to fill out.)***

What happened to cause the condition(s)? If you are not sure, just write "unknown".

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Name____ Date: _____/_____/_________

How long has this been bothering you?

____

Has this bothered you **before**? When?

____

Please list **other health care providers** you have seen for the condition(s), and **treatment** received.

____

____

Have you found any activities that make your complaints feel better? (Examples are ice, heat, stretching, other treatment)

____

____

Describe briefly and give approximate dates for any **major injuries, illnesses, surgeries or accidents**:

____

____

____

Does your immediate family have a history of any diseases? (Cancer, Heart Disease, Diabetes, Etc.)

Mother's side ____

Father's side ____

Are you presently on any medications? (please specify)

____

____

Do you smoke? ❑Yes ❑No Drink Alcohol? ❑Yes ❑No Number of drinks per week _________

Exercise Regularly? ❑Yes ❑No

Height__________ Weight______________

Have you been to a chiropractor before? ❑Yes ❑No

Chiropractor's name/ location: ____ Last seen: ____________________

Name of Primary Care Physician______________________________ Date of last Physical______________________

Please provide your email address if you wish to be added to our monthly e-newsletter list.

Email: **____**

____ _______________

Patient Signature (Guardian if under 18) **Date**

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Name____ Date: ____/____/________

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period:______________

Signature:____ _Date:_______________________

HEALTH INSURANCE INFORMATION

Patient's Name_______________________________________ ***DOB***____________________________

Insured's Name_______________________________________ ***Insured's DOB***____________________

Insured's Address if different than yours____

____

ID#____ **Group#**___________________

Insurance Company___________________________________

Please present insurance card to front desk so we can make a copy for your file.

***If not insured, list the Name & Address of person RESPONSIBLE FOR PAYMENT.**

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VERY IMPORTANT------PLEASE READ AND SIGN BELOW

ASSIGNMENT OF INSURANCE BENEFITS

I understand that as a courtesy Rainier Valley Chiropractic, P.S. will attempt to verify my Chiropractic and/or Massage benefits but that I should confirm my benefits on my own as well. Benefit quotes are not a guarantee of payment. I understand that ultimately I am responsible for charges not covered by my insurance.

I hereby authorize payment directly to Rainier Valley Chiropractic, P.S. for the chiropractic services that I am provided.

Signature: ____ Date:________________

(_Policy Holder/Child's Guardian)_