CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Last Name First Middle Initial	SSN:	Date of Birth:	Sex: ❑M ❑F
Street Address:	Home Phone:	Cell Phone:	Preferred: ❑Home ❑Cell ❑Work
Email:	Emergency Contact:	Emergency Contact Number:	
Occupation:	Employer:	Work Phone:	

Would you like to receive appointment reminders? Choose ONE:
❑Email ❑Text Message ❑BOTH Text and Email ❑None

INSURANCE INFORMATION

Primary Insurance:	Insured ID:
Insured Name:	Group Number:
Patient is the ❑Spouse ❑Child ❑Self ❑_____ to the insured.	Ins. Date of Birth:
Insured Address (if different from patient):	
Address 2: City: State: Zip Code:	
Deductible:	Coinsurance/Copay:
Secondary Insurance:	Insured ID:
Insured Name (secondary):	Insured Date of Birth (Secondary):

AUTOMOBILE INSURANCE INFORMATION

Insurance Company:	Policy Number:
Claim Number:	Date of Crash:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment. B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case, and by any insurance company contractually obligated to make payment to me or this office based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT SIGNATURE	DATE
SIGNATURE OF GUARDIAN	**RELATIONSHIP TO MINOR**

Spine and Whiplash Center **1552 Broadway | Longview, WA 98632 | 360.577.8442**

PAST HEALTH HISTORY

Name:	Date:

Have you ever received Chiropractic care?

❑Yes ❑No

If yes, when? Name of most recent Chiropractor:

Please indicate if **YOU** have a history of any of the following:

❑Anticoagulant Use	❑Heart Problems	❑High Blood Pressure	❑Chest Pain
❑Bleeding Problems	❑Lung Problems	❑Shortness of Breath	❑Cancer
❑Diabetes	❑Major Depression	❑Bipolar Disorders	❑Psychiatric Disorders
❑Schizophrenia	❑Stroke/TIA	❑Other:_____	

❑NONE OF THE ABOVE

Please list any previous injury or trauma:

Please list any broken bones:

Please list any allergies:

Please list your current medications:

Medication:	Reason for taking:

Please list any surgeries you have had:

Date:	Type of Surgery:

Females Only:

Number of Pregnancies: Number of Births: Were Pregnancies Normal? ❑Yes ❑No

Do you have a **FAMILY** history of (please check all that apply)?

❑Cancer	❑Strokes/TIA	❑Headaches	❑Cardiac Disease Below Age 40
❑Diabetes	❑Psychiatric Disease	❑Psychiatric Disorders	

❑Other (please describe):

❑NONE OF THE ABOVE

PAST HEALTH HISTORY (continued)

Social and Occupational History:

Job Description:

Work Schedule:

Recreational Activities:

Lifestyle

Do you smoke? ❑Yes ❑No Packs per day: How many years:

Do you consume alcohol? ❑Yes ❑No Drinks per day:

Do you exercise: ❑Yes ❑No Days per week:

Type of exercise:

Have you had any of the following **PULMONARY** (lung related) issues?

❑Asthma ❑Difficulty Breathing ❑COPD ❑Emphysema

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **CARDIOVASCULAR** (heart related) issues or procedures?

❑Heart Surgeries ❑Heart Attack ❑Heart Disease ❑Congestive Heart Failure
❑Hypertension ❑Pacemaker ❑Angina ❑Murmurs/Valve Disease
❑Chest Pain ❑Chest Pain ❑Irregular Heartbeat

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **NEUROLOGICAL** (nerve related) issues?

❑Visual Changes ❑Loss of Vision ❑Vertigo ❑One-Sided Weakness of Face or Body
❑History of Seizures ❑Headaches ❑Memory Loss ❑One-Sided Decreased Feeling in Face or Body
❑Tremors ❑Stroke/TIA ❑Loss of Sense of Smell

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **ENDOCRINE** (glandular/hormonal) related issues or procedures?

❑Thyroid Disease ❑Hormone Replacement Therapy ❑Injectable Steroid Replacements
❑Diabetes

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **RENAL** (kidney-related) issues or procedures?

❑Renal Calculi/Stones ❑Blood in Urine ❑Bladder Infections ❑Incontinence (can't control)
❑Difficulty Urinating ❑Kidney Disease ❑Dialysis

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **GASTROENTEROLOGICAL** (stomach-related) issues?

❑Nausea ❑Difficulty Swallowing ❑Ulcerative Disease ❑Hiatal Hernia
❑Pancreatic Disease ❑Frequent Abdominal Pain ❑Irritable Bowel/Colitis ❑Constipation
❑Vomiting Blood ❑Bowel Incontinence ❑Hepatic or Liver Disease ❑Heartburn
❑Bloody or Black Tarry Stools

❑Other (please describe): ❑NONE OF THE ABOVE

PAST HEALTH HISTORY (continued)

Have you had any of the following **HEMATOLOGICAL** (blood related) issues?

❑Anemia ❑Enlarged Lymph Nodes ❑Abnormal Bleeding ❑Abnormal Bruising
❑HIV Positive ❑Sickle-Cell Anemia ❑Hemophilia ❑Anticoagulant Therapy
❑Regular Aspirin Use ❑Enlarged Lymph Nodes ❑Blood Clots ❑Deep Vein Thrombosis
❑Regular Anti-inflammatory Use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **DERMATOLOGICAL** (skin related) issues?

❑Significant Burns ❑Significant Rashes ❑Skin Grafts ❑Psoriatic Disorders

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **MUSCULOSKELETAL** (bone or muscle related) issues?

❑Rheumatoid Arthritis ❑Osteoarthritis ❑Broken Bones ❑Spinal Fracture
❑Spinal Surgery ❑Joint Surgery ❑Gout ❑Arthritis (unknown type)
❑Scoliosis ❑Metal Implants

❑Other (please describe): ❑NONE OF THE ABOVE

Have you had any of the following **PSYCHOLOGICAL** related issues?

❑Psychiatric Diagnosis ❑Depression ❑Bipolar Disorder ❑Schizophrenia
❑Psychiatric Hospitalization ❑Suicidal Thoughts ❑Homicidal Thoughts

❑Other (please describe): ❑NONE OF THE ABOVE

Is there anything else in your past medical history that you feel is important to your care here? (please describe)

ACKNOWLEDGEMENT

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this clinic to provide me with chiropractic care, in accordance with this state's statutes.

Signature:	Date: