New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data:

Name_____ Date_____ Email_____

your email will not be shared with any 3rd parties, and is used for general office announcements and promotions.

Mailing Address:

Address_____City_____ State_____ Zip_____

Telephone (cell)_____(work)_____Referred by_____

Age_____ Birth date_____ Number of children_____

Occupation_____ Employer_____

Marital Status _____ Spouse's name _____ Spouse occupation_____

Emergency Contact _____ Phone_____

Current Complaints:

Chief Complaint:_____

Injury Y/N Type of injury: Auto Work Other _____

Date of injury _____ Date symptoms appeared _____

Have you ever had a similar condition? Y/N If yes, when?_____

List other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? Y/N

If yes please describe experience _____

Medical History

Have you been treated for any other conditions this year? Y/N

If yes please describe _____

Date of last physical exam _____ Is there a chance you are pregnant? Y/N

What medications are you taking and for what conditions_____

_____

What vitamins, minerals or herbs do you currently take?_____

_____

Have you ever:

Broken bones Y/N _____

Been hospitalized Y/N _____

Been in an auto accident Y/N_____

Had sprains/strains Y/N _____

Been struck unconscious Y/N _____

Had surgery Y/N _____

Habits:	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	__	__	__	__
Coffee	__	__	__	__
Tobacco	__	__	__	__
Marijuana	__	__	__	__
Exercise	__	__	__	__
Sleep	__	__	__	__
Appetite	__	__	__	__
Soft Drinks	__	__	__	__
Water	__	__	__	__
Salty Foods	__	__	__	__
Sugary Foods	__	__	__	__
Artificial Sweeteners	__	__	__	__

Have you ever suffered from (check):

Alcoholism__
Allergies__
Anemia__
Arteriosclerosis__
Arthritis__
Asthma__
Back pain__
Breast lump__
Bronchitis__
Bruise easily__
Cancer__
Chest pain/conditions__
Cold extremities__
Constipation__
Cramps__
Depression__
Diabetes__
Loss of smell__
Loss of taste__
Lumps in breast__
Neck pain/stiffness__
Nervousness__
Nosebleeds__
Digestion problems__
Dizziness__
Ears ring__
Excessive menstruation__
Eye pain/difficulties__
Fatigue__
Frequent Urination__
Polio__
Poor posture__
Prostrate trouble__
Sciatica__
Shortness of breath__
Sinus infection__
Sleep problems/insomnia__
Spinal curvatures__
Stroke__
Swelling of ankles__
Swollen joints__
Thyroid Conditions__
Tuberculosis__
Ulcers__
Varicose veins__
Venereal disease__
Loss of Memory__
High Blood Pressure__
Hot Flashes__
Irregular Heart Beat__
Irregular Cycle__
Kidney Infection__
Kidney Stones__
Headaches__
Hemorrhoids__
Other__

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both th e objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or injury.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes irritation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I have read and fully understand the above statement. Any questions regarding the doctors objective pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

Sign:_____-

PATIENT PRIVACY NOTICE

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with the notice describing.

How Medical information about you may be used and disclosed and how you can access this information:

We are required by law to have your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without you consent or authorization.

As our patient you have important rights relating to inspection and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restricted certain uses and disclosures of you health information and complaining that you thinks your rights have been violated.

You have the right to receive a copy of our most current notice in effect. If you have not yet reserved a copy of your current notice, please ask at the front desk and we well provide you with a copy.

If you have any questions, concerns, or complaints about the notice of your medical information, please contact our office at 7117 Stinson Ave. Suite C. Gig Harbor, WA 98335 253-857-7788

Sign:_____