POSITIVE CHIROPRACTIC
AND WELLNESS

Call 425-820-2773

Patient Confidential Health Record Form

Name:_________________________________ Date of Birth:_________________ Today date:_______________

Home Phone: _______________Cell Phone:_________________ Email:__________________________________

Address:____City:___________ State:____ Zip Code:_________

Social Security:_______________ Check one: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Business Employer:_____________________________ Type of Work:__________________________

Emergency Contact: _______________________ Relationship:____________ Cell Phone:__________________

Who is responsible for your bill? ☐My Health Insurance☐Cash☐Auto Insurance☐Labor Industries☐Other_______

Current Health Condition

Unwanted Health Condition:____________________________________

Other Doctor seen for this condition? ☐Yes ☐No Who?_______________________________________

Type of Treatment:______________ Results:_____________________

When did this condition begin?_______________ Has this condition occurred before?_________________

Is condition :☐Job Related ☐Auto Accident ☐Home Injury ☐Fall ☐Other_________________

Drugs you now take:_____________________ Do you wear a shoe lift?_____________

Do you suffer from ant condition other than that which you are now consulting us? ___________________

Past Health History

☐Major Surgery/Operations: ☐Appendectomy ☐Tonsillectomy ☐Gall Bladder ☐Back Surgery ☐Broken Bones

☐Other:_______________ Major Accident or Falls:____

Hospitalization(other than above):____

Previous Chiropractic Care: ☐None ☐Doctor's Name& Date of last visit:_____________________________

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

☐Pneumonia☐Mumps☐Influenza☐Rheumatic☐Small Pox☐Pleurisy☐Polio☐Chicken Pox☐Arthritis☐Tuberculosis ☐Diabetes☐Epilepsy☐Whooping Cough☐Cancer☐Mental Disorders☐Anemia☐Heart Disease☐Lumbago ☐Measles☐Thyroid☐Eczema

Intake: ☐Coffee ☐Tea ☐Alcohol ☐Cigarettes ☐White Sugar

Have you been tested HIV positive? ☐Yes ☐No

Check any of the following you have had the past 6 months:

Muscular-Skeletal Code: ☐Low Back Pain ☐Pain Between Shoulders☐Neck Pain☐Arm Pain☐Joint Pain/Stiffness ☐Walking Problems☐Difficult Chewing/Clicking Jaw☐General Stiffness☐Gas/Bloating after meals☐Heartburn ☐Black/Bloody Stool☐Colitis

Genito-Urinary Code: ☐Bladder Trouble☐Painful/Excessive Urination☐Discolored Urine

Nervous System Code:☐Nervous☐Numbness☐Paralysis☐Dizziness☐Forgetfulness☐Confusion/Depression☐Fainting ☐Convulsions☐Cold/Tingling Extremities☐Stress

C-V-R Code: ☐Chest Pain☐Short Breath☐Blood Pressure Problems☐Irregular Heartbeat☐Heart Problems☐Lung Problem/Congestion☐Varicose Veins☐Ankle Swelling☐Stroke

General Code: ☐Fatigue☐Allergies☐Loss of Sleep☐Fever☐Headaches

EENT Code: ☐Vison Problems☐Dental Problems☐Sore Throat☐Ear Aches☐Hearing Difficulty☐Stuffed Nose

Gastro-Intestinal Code: ☐Poor/Excessive Appetite☐Excessive Thirst☐Frequent Nausea☐Vomiting☐Diarrhea ☐Constipation☐Hemorrhoids☐Liver Problems☐Gall Bladder Problems☐Weight Trouble☐Abdominal Cramps

Male/Female Code: ☐Menstrual Irregularity☐Menstrual Cramps☐Vaginal Pain/Infection☐Breast Pain/Lumps ☐Prostate/Sexual Dysfunction☐Other Problems:___________

Family History: The following members have a same or similar problem as I do:
☐Mother☐Father☐Brother☐Sister☐Spouse☐Child

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection form the insurance company and that any amount authorized to be pain directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understand and agreed the amount paid the Doctor, for X-Rays, is for examination only and X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: ____ Date :___________________________