Application For Treatment Clark Chiropractic 17422 108th Ave SE Renton, WA 98055

Patient Information — **Please Print Clearly**

Patients Name:_____ Todays Date: _____
Date of Birth _____ Age ___ Social Security #_____ Marital Status S M D W
Home Address: _____ City: _____ State: __ Zip: _____
Home Phone:_____ Cell Phone: _____Work Phone: _____
Spouses Name: _____ Ages Of Children:_____
Occupation:_____ Employer: _____
Prior Chiropractic Care? Y/N When: _____ Where: _____ X-Rays: _____
Who referred you to our office:_____

Insurance Information

Primary Insurance: _____ Phone: _____
Insurance Address:_____ City: _____ State: __ Zip_____
Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Date of Birth: _____ ID# _____ Group#: _____
Secondary Insurance:_____ Phone: _____
Insurance Address:_____ City: _____ State:__ Zip: _____
Subscriber's Name: _____ Relationship to Patient: _____

Chief Complaint/Reason for this Appointment:

_____

_____

Additional problems or concerns:

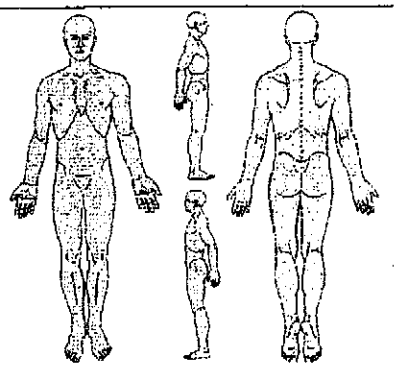
_____

What treatment have you already had for these conditions?

_____

_____

How long have you had this complaint?: _____
Have you had similar symptoms before: ☐Yes ☐No When: _____
Please describe the pain and its location _____
Circle the intensity of your pain (0=no pain, 10=worst pain) 0 1 2 3 4 5 6 7 8 9 10



(Mark Your Areas Of Complaints)

Is this condition due to a: ☐ Auto accident ☐ Work Injury ☐ Other Accident ☐ Illness ☐ Unknown Cause
Have you lost time from work? ☐ Yes ☐ No Dates Lost: _____
Was your time loss Dr. ordered? ☐ Yes ☐ No Self determined: ☐ Yes ☐ No
Are you symptoms generally? ☐ Improving ☐ Getting Worse ☐ About the same ☐ Intermittent (comes & goes)
Effect on Daily Activities ☐ No effect ☐ Extra effort ☐ Occasional Limitation ☐ Frequent or severe limit
Have you ever smoked cigarettes? ☐ Yes ☐ No If yes, ___ Packs per day, for ___ years. ☐ Currently smoke.
Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, ___ Per day
Previous drug or alcohol problems? ☐ Yes ☐ No Do you drink alcohol ☐ Yes ☐ No ___ per day/week
Do you exercise regularly? ☐ Yes ☐ No Type/Frequency:_____
Do you sleep soundly? ☐ Yes ☐ No Hobbies/Recreational Activities? _____

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to the physician. I am financially responsible for any balance due including all interest and finance charges as allowed by state law. I also authorize the Doctor or Insurance Company to release any information required to process this claim. I further agree to the filling of a lien to secure payment or judgment for any claim I have against a third party for injuries/illness. I hereby acknowledge and understand that all charges incurred in this office are my responsibility. Should my insurance company, for any reason, fail to pay for any services rendered, I will pay for such services upon notification by a representative of the clinic.

SIGNATURE: _____ DATE: _____

Please Complete Page 2-Over

Clark Chiropractic 17422 108th Ave SE, Renton, WA 98055

Patient Name: Date:

PAST MEDICAL HISTORY (Circle)

Aids, HIV	Alcoholism	Allergy
Arthritis	Asthma	Cancer
Cholesterol	Depression	Diabetes
Epilepsy	Heart Disease	Hepatitis
Herniated disk	Osteoporosis	Pacemaker
Pinched nerve	Prostate	Stroke
Suicidal thoughts	Thyroid	Tuberculosis
Tumors	Venereal disease	High Blood Pressure

Surgery _____

_____

Other injuries/accidents _____

_____

Family History: _____

SOCIAL HISTORY:

Education level completed: _____

Children (list ages): _____

Major stress in last 6 months?: _____

_____

YOUR HEALTH CARE TEAM

Family Physician: _____ Phone: _____

Other Specialist: _____ Phone: _____

Have you ever seen:

□ Chiropractor Name_____

□ Acupuncture Name_____

□ Massage therapist Name_____

REVIEW OF SYSTEMS: (circle current problems, check past problems)

Constitutional
__Decreased sleep
__irregular sleep
__poor appetite
__fevers
__chills
__food cravings
__weight loss
__weight gain
__fatigue

Immune System
__too many infections
__allergies to food or environment
__other concerns

Mood, Thoughts, and Emotions
__manic episodes
__energy problems
__spiritual needs
__anger problems
__depression
__loneliness
__apathy
__don't care anymore
__panic or fear attacks
__anxiety, over stressed
__hopelessness
__isolated from family, friends, or coworkers

Skin, Hair, Breasts
__breast lumps or pain
__breast leaks fluid
__rashes
__itching, hives
__hair loss
__mole changes
__dry skin, eczema

Ears, Nose, Mouth, Throat
__ringing ears
__nose bleeds
__postnasal drip
__sinus problems
__trouble with taste/smell
__poor hearing
__earaches
__bad breath
__headaches
__facial pain
__jaw clicks
__teeth problems
__grinding teeth
__trouble chewing
__sore throats

Eyes
__eye pain
__blurred vision
__poor vision__day__night
__wear corrective lenses
__near__far sighted
__other:

Breathing and Lungs
__shortness of breath
__wheezing or asthma
__repeated colds and flus
__cough, dry or irritating
__cough up mucous or blood

Heart & circulation
__chest pain
__lightheadedness
__palpitations
__cold hands/feet
__fainting
__swelling feet
__blood clots
__varicose veins

Digestion and Intestines
__Indigestion
__belching
__difficulty swallowing
__heartburn
__nausea
__liver trouble
__vomiting
__blood in stools
__diarrhea
__foods that upset your system
_____
__cramping bowels
__gassy gut
__constipation
__abdominal pain
__rectal pain or itching
__hemorrhoids, piles

Nerves, Movement, Brain
__seizures
__nerve pains
__poor balance
__poor coordination
__tremors or shaking
__numbness
__dizziness
__poor memory
__trouble sleeping

Muscles, bones, and joints
__neck pain
__back pain
__muscle pain
__muscle weakness
__muscle cramps
__joint swelling
__painful joints: __R__L

Urine, kidneys, Bladder
__Decreased urine flow
__Blood or pus in urine
__Painful urination
__wake up to urinate
__kidney stones
__loss control of urine
__sudden urges to pee
__frequent urination

Women's Reproductive
__number of children
__miscarriage
__past fertility problems
__age period stopped, menopause

Sexual Organs
__sores on genitals
__lumps or swellings
__erection problems
__poor sexual response
__pain with sex
__infertility
__repeated infections

Women:
__pelvic pain
__vaginal discharge
__painful periods
__premenstrual syndrome
__hot flashes
__itching or soreness

Blood System
__lymph gland swelling
__anemia
__easy bruising

Hormones and Metabolism
__thyroid trouble
__fluid retention
__weight and diet trouble