HERITAGE chiropractic

(253) 475-3334
13412 Pacific Ave S
Tacoma, WA 98444

Date: ________________

CONFIDENTIAL PATIENT INFORMATION

First Name ______________________ Last Name _____________________ MI _____ DOB _____________ Age ______ Sex ________

Street Address ____

City ____ State ____________________ Zip ______________

Home Phone ____________________________ Work Phone _____________________ Cell # _______________

Occupation __________________________ Employer __________________________ SS # _______________

Martial Status M / S / W / D / Sep. Children at home: Name/Age ____

Spouse __________________________ Age _______ Occupation ________________ Work Phone ______________

How is the account to be paid: Self Medicare Workman's' Comp. Auto Insurance Personal Health Insurance

Other ____

Referred by: ______________________________________ Email Address: ______________________________

Can we contact you via text? Yes No Can we contact you via Email Address? Yes No

PAYMENT EXPECTED AT TIME OF VISIT - UNLESS OTHER ARRANGEMENTS ARE MADE

CURRENT HEALTH CONDITION

Purpose of this appointment: ____

____

When did this condition begin? ____

____

How would you classify your condition? Minor Involved Fairly severe, getting worse Serious

Other doctors seen for this condition _____________________________ D.C. D.O. M.D.

If disabled from work, please give dates ____

Job related? Work related? If so, see also last page

Prescription drugs you now take: Pain killers Muscle relaxars Blood pressure Sedative Insulin

Birth Control Other ____

Non-prescription drugs you now take ____

Medication recommended but not taking at the present ______________________________________

Check appropriate boxes:

Symptoms: come and go came on gradually came on suddenly (give date: ______________)

Symtoms have persisted for: days weeks months years

Symptoms are worse in: AM Midday PM Night

Symptoms are better in: AM Midday PM Night

Type of pain: Dull Sharp Throbbing Burning Radiating Pins and Needles Other __________

What activities make symptoms worse? ____

What activities make symptoms better? ____

OTHER HEALTH HISTORY

Date of last physical exam ______________ Reason ______________ Date last X-rays ____________________

Caesarean Broken Bones Other ____

Major Accidents/Falls ____

____

Have you been treated by a physician in the last year? Yes No

Describe ____________________________ Doctor ____________________________ D.C. D.O. M.D.

Previous Chiropractic Care: Yes No if yes, Dr./date(s) ______________________ Reason ______________

I hereby authorize HERITAGE CHIROPRACTIC CLINIC to release medical information if necessary to process this claim.

Signed: ____ Date: ____________________

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection
Diptheria	Whooping Cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Mental Disorder
Rheumatic Fever	Mumps	Influenza	Lumbago
Polio	Small Pox	Pleurisy	Eczema
	Autoimmune Disorders	Stroke	Thyroid Disease

CHECK ANY OF THE FOLLOWING YOU NOW HAVE OR HAVE HAD IN THE PAST:

Frequently Occassionally Never

MS
Headache
Neck Pain
Pain between shoulders blade
Shoulder Pain
Arm Pain/Tingling/Numb
Mid Back Pain
Low Back Pain
Hip pain
Leg pain/Tingling/numb
Walking problems
Difficult chewing/Clicking jaw

NS
Dizziness
Balance/Equilibrium
Blurred Vision
Loss of Concentration
Forgetfulness
Stress
Depression/Confusion
Anxiety/Nervousness
Sleep Disturbance
Energy Loss/Fatigue
Tired AM/PM
Buzzing/Ringing in ears
Fainting
Palpitations

GI
Indigestion
Poor/Excessive appetite
Excessive Thirst
Frequently nausea
Vomiting
Constipation
Sudden changes in weight in 6 months
Hemorrhoids
Liver trouble
Gall Bladder problems
Weight trouble
Abdominal Cramps
Gas/Bloating after meals
Heartburn
Black/Bloody Stool
Colitis

GU
Kidneys/Bladder Trouble
Painful/Excessive Urination
Discolored Urine

CVR
Poor Circulation
Chest Pain
Short Breath
Blood Pressure problems
Irregular Heartbeat
Heart problems
Luna problems/Congestion
Varicose Veins
Ankle Swelling

ENT
Vision problems
Dental problems
Sore Threat
Fever
Ear Aches
Hearing difficulty
Stuffed Nose/Sinus
Allergy
Bloody Nose

Familial History

Cancer	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Arthritis	Yes	No
Osteoporosis	Yes	No
High Cholesterol	Yes	No

Habits

Do you smoke Yes No
How much ________________________ /day
Alcohol ________________________________
Vitamins? ______________________________
Type of bed you sleep on ________________

Female

Menstrual Irregularity
Menstrual Cramping
Vaginal pain/Infections
Breast pain/Lumps
Sexually Transmitted Disease
Back pain with menses

Are you pregnant Yes No
Date of last period ______________________

Male

Prostrate Dysfunction
Sexual Dysfunction
Sexually Transmitted Disease
Trouble Urinating

INDICATE, CHECK (✓) ANY DIFFICULTY TO PERFORM THE FOLLOWING ACTIVITIES

Coughing or Sneezing	Sitting at table	Stooping	Climbing
Getting in or out of car	Lying on back Gripping	Gripping	Lying flat on Stomach
Bending forward to brush teeth	Kneeling	Pushing	Lying flat on side with knees bent
Turning over in bed	Balancing	Pulling	Bending over forward
Walking short distances	Dressing Self	Reaching	
Standing for more than 1 hour	Sleeping	Sex Activity	

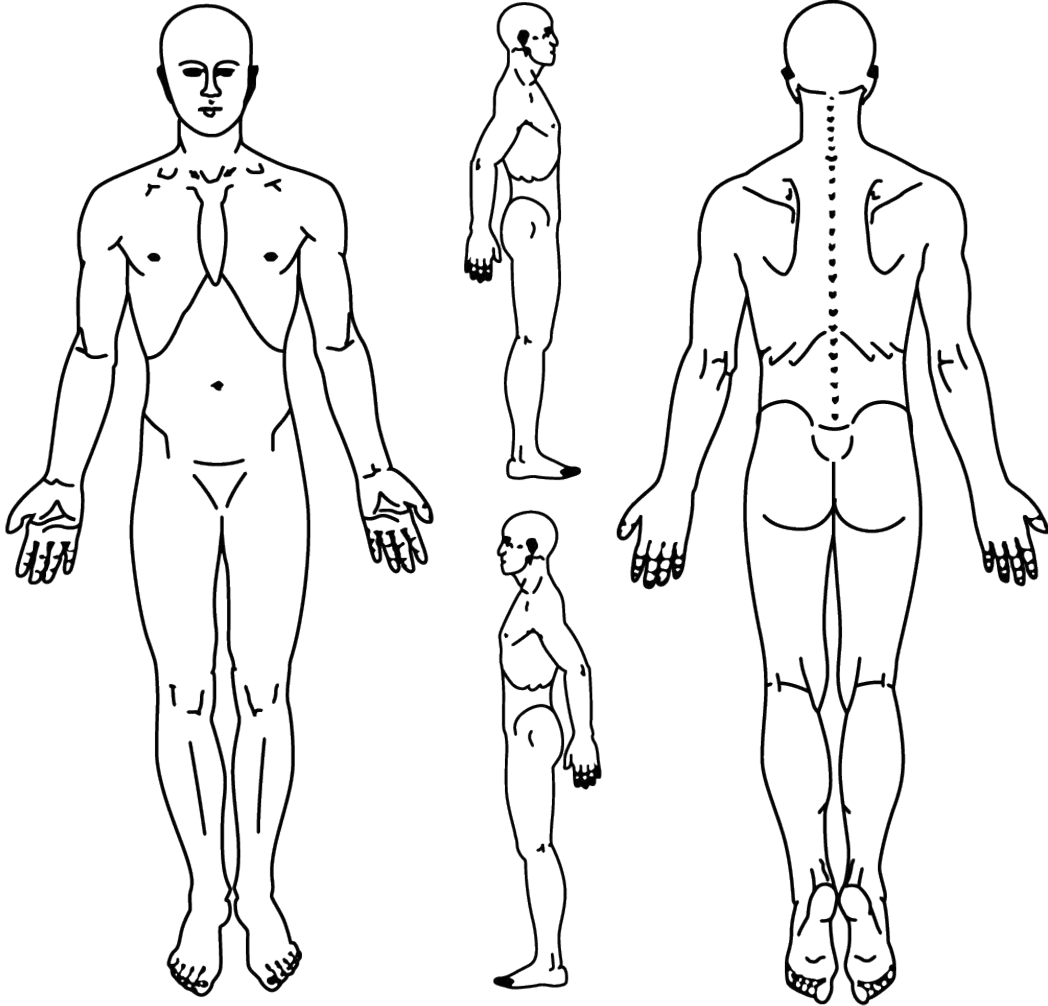
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that HERITAGE CHIROPRACTIC CLINIC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to HERITAGE CHIROPRACTIC CLINIC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Any accounts that are referred for collection will have a service fee charged at the time of referral to cover additional handling cost. Should legal action be necessary for the recovery of any monies due under this agreement, the prevailing party shall be entitled to recover attorney fees and court costs from the other party. Any disputes between parties shall be resolved by binding arbitration. It is not our intention to cause you undue hardship, however we must collect our receivables as efficiently as possible in order to continue our service to the community. Interest of 11/2% per month will be charged on delinquent accounts. If you discontinue your care, all charges are due and payable immediately.

Parent's Signature ____________________ Social Sec. No. ____________________ Driver's License # __________________
Guardian or Spouse's Signature Authorizing Care: ____ Date: __________________

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	O O O O O	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - - - - -	O O O O O	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



Please use the space below to describe your condition further if needed:

____

____

____

Date: ______________________ Signature: ____