

ADVANCED CHIROPRACTIC

9212 EVERGREN WAY EVERETT WA 98204

425-353-7246

CONFIDENTIAL PATIENT INFORMATION

NAME: _____ DOB: _____ GENDER: M/F DATE: _____
CELL PHONE: () _____ EMAIL: _____
HOME PHONE: () _____ SS# _____
ADDRESS: _____ APT #: _____
CITY: _____ STATE: _____ ZIP: _____

PARENT/GUARDIAN'S NAME IF MINOR _____
ADDRESS OF PARENT/GUARDIAN IF DIFFERENT THAN ABOVE: _____
CELL PHONE: () _____ HOME PHONE: () _____

EMPLOYER: _____ OCCUPATION: _____
WORK #: () _____ EXT: _____
SPOUSE/EMERGENCY CONTACT: _____ CELL #: () _____

WHO CAN WE THANK FOR YOUR REFERRAL? _____

IS THIS DUE TO AN AUTO OR WORK RELATED INJURY? YES NO BOTH DATE OF INJURY: _____

WILL YOU BE USING HEALTH INSURANCE? YES NO

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you to receive the care you need without undue financial strain. As a courtesy, this office will bill your insurance company for you. I hereby instruct my insurance company to pay this office for professional services rendered. I understand that the contract I have is between me and the insurance company which holds my contract. In the event that my insurance company fails to pay, the outstanding bill is ultimately my responsibility. I agree to be financially responsible for all charges incurred at this office, including my insurance deductible, co-payments and any services rejected by my insurance company. **It is understood that payment is expected at the time of service.** Unless otherwise arranged, a service charge of one percent will be added to any balance 30 days past due. **This office reserves the right to charge me for any missed appointments not cancelled 24 hours prior to the appointment.**

My signature below grants permission to be treated by the doctors of Advanced Chiropractic and authorizes this clinic to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case. A photocopy of this assignment shall be considered effective and valid as the original.

I hereby give consent to the doctor(s) in this clinic to recommend and/or perform any necessary treatment, testing or procedures they deem necessary for my healthcare needs.

 Patient or Guardian's Signature: _____

(For office use only) ACCT # _____

PATIENT NAME: _____ DATE: _____

1. Are you having: Neck pain, Upper back pain, Mid back pain, Low back pain, Shoulder pain or Headaches?

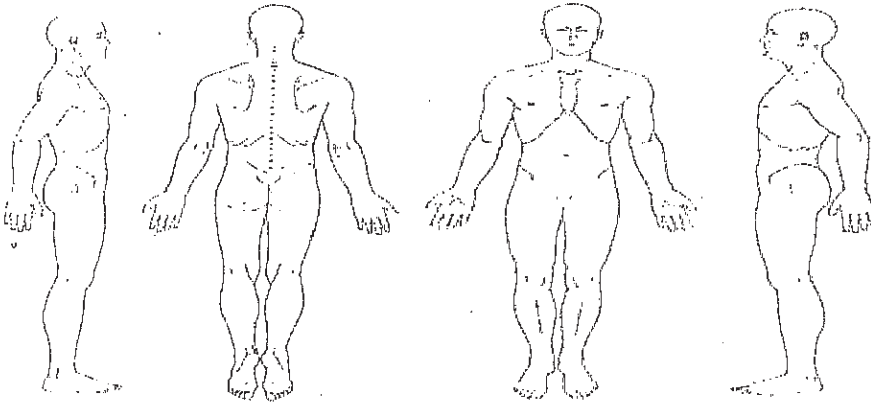
2. When did your symptoms start? _____ b. **HOW** did THESE symptoms Begin? _____

3. Describe any other Symptoms: _____

4. How often do you experience your symptoms? Constantly (76-100% of the day) Frequently (51-75% of the day)
Occasionally (26-50% of the day) Intermittently (0-25% of the day)

5. Have you had similar symptoms BEFORE THIS episode? Yes / No. How often _____

INDICATE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



4. What do your symptoms feel like? Sharp Dull Achy Numb Shooting Burning Tingling

5. How are your symptoms changing? Getting Better Not Changing Getting Worse

6. What are you doing for your problem: Ibuprofen, Tylenol, Aleve, Prescription Medications, Stretching, Massage, Ice, Heat, or _____

7. During the past 4 weeks: a. Indicate the average intensity of your symptoms
None/0 1 2 3 4 5 6 7 8 9 10/Unbearable

a. Rate the severity of your symptoms TODAY
None/0 1 2 3 4 5 6 7 8 9 10/Unbearable

b. How much has pain interfered with your normal life: Not at A little Moderately Extremely

8. List any surgeries you have had _____

9. In general would you say your overall health right now is...
Excellent Very Good Good Fair Poor
10. Who have you seen for YOUR PRESENT symptoms? No one Chiropractor MD PT Other
Name / phone number of the doctor _____

Have you had X-rays / MRI for THIS PROBLEM Where _____ When _____

Signature _____ File # _____