RED-ROSE CHIROPRACTIC CLINIC, P.S.

12841 NE 85TH STREET • KIRKLAND, WA 98033 • (425) 893-9200 • fax (425) 893-8046

PATIENT INFORMATION **DATE:** BP: P:

Patient Name: (First) _____ (Last) _____ (M.I.)_____

Address: _____ City, State:_____ Zip Code:_____

Home #: (_____)_____ Cell #: (_____)_____ Work #: (_____)_____

Date of Birth: _____ Age: _____ Sex: M / F Email: _____

Automatic Appointment Reminder Contact Method: ☐ Text Message ☐ Email (Consent with signature below)

Height:_____ Weight: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: _____ Phone: (____)_____

Employer:_____ Occupation:_____ Primary Care Physician:_____

Pregnant? ☐ Yes ☐ No ☐ Unsure If yes, Due date: _____ (Please inform us of any changes asap)

Previous Chiropractic? ☐ Yes ☐ No If so, who: _____ Date of last visit: _____

Whom may we thank for referring you? _____

Preferred Language: ☐ English ☐ Other: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer

Race: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Decline to Answer

AUTHORIZATION OF TREATMENT AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I authorize this office and its staff to examine and treat my condition as the doctor(s) see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I also agree to automatic appointment reminders sent by the clinic. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment. I understand any payments due not tendered within 120 days from the initial statement date will be sent to out the collections agency we keep on retainer (Olympic Collections).

( ) I agree with this statement of authorization

Patient Name (Print): _____ Date: _____

Patient Signature: _____ Date of birth: _____

Consent to Treat a Minor (Minor's Printed Name): _____

Guardian Authorizing Care (Signature): _____ Relationship: _____ _____

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PRESENT CONDITIONS ***** Please list only 1 area of complaint per page*****

***Primary* Complaint**: What has prompted you to seek care? _____

Date of Onset: _____ How did it Happen? _____

On a scale of 0-10, rate your pain level ***Today***: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, rate your pain level ***At Its Worst***: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, rate your pain level ***At Its Best***: 0 1 2 3 4 5 6 7 8 9 10

How much of the time do you have this pain?: ☐ Constantly (100%) ☐ Frequently (99%-75%) ☐ Intermittently (74%-50%)
☐ Occasionally (49%-25%) ☐ Recurring (24%-1%) ☐ Randomly (inconsistent)

What is the quality of your symptoms?: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Deep ☐ Shooting ☐ Tight
☐ Aching ☐ Tingling ☐ Stabbing ☐ Cramping ☐ Numbness ☐ Radiating ☐ Other _____

Are any other areas affected by this same pain, and how?_____

What makes it better?:

☐ Medication ☐ Rest
☐ Homeopathic Remedies ☐ Physical Therapy
☐ Surgery ☐ Acupuncture
☐ Chiropractic ☐ Massage
☐ Ice ☐ Heat ☐ Other: _____

What makes it worse?

☐ Movement ☐ Pressure
☐ Sitting ☐ Standing
☐ Changing Positions ☐ Coughing/Sneezing
☐ Bending ☐ Twisting
☐ Lifting ☐ Other: _____

Have you sought any other care for this complaint? ☐ Yes ☐ No What/When?: _____

Is this condition interfering with work? ☐ Yes ☐ No How?: _____

Is this condition interfering with daily activities or hobbies/sports? ☐ Yes ☐ No How?: _____

Have you had any diagnostic tests or imaging performed regarding this complaint? ☐ Yes ☐ No

When: _____ Where: _____ Do you have copies?: ☐ Yes ☐ No

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PRESENT CONDITIONS ***** Please list only 1 area of complaint per page*****

***Secondary* Complaint**: What has prompted you to seek care? _____

Date of Onset: _____ How did it Happen? _____

On a scale of 0-10, rate your pain level ***Today***: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, rate your pain level ***At Its Worst***: 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, rate your pain level ***At Its Best***: 0 1 2 3 4 5 6 7 8 9 10

How much of the time do you have this pain?: ☐ Constantly (100%) ☐ Frequently (99%-75%) ☐ Intermittently (74%-50%)

☐ Occasionally (49%-25%) ☐ Recurring (24%-1%) ☐ Randomly (inconsistent)

What is the quality of your symptoms: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Deep ☐ Shooting ☐ Tight

☐ Aching ☐ Tingling ☐ Stabbing ☐ Cramping ☐ Numbness ☐ Radiating ☐ Other _____

Are any other areas affected by this same pain, and how?_____

What makes it better?:

☐ Medication ☐ Rest

☐ Homeopathic Remedies ☐ Physical Therapy

☐ Surgery ☐ Acupuncture

☐ Chiropractic ☐ Massage

☐ Ice ☐ Heat ☐ Other: _____

What makes it worse?

☐ Movement ☐ Pressure

☐ Sitting ☐ Standing

☐ Changing Positions ☐ Coughing/Sneezing

☐ Bending ☐ Twisting

☐ Lifting ☐ Other: _____

Have you sought any other care for this complaint? ☐ Yes ☐ No What/When?: _____

Is this condition interfering with work? ☐ Yes ☐ No How?: _____

Is this condition interfering with daily activities or hobbies/sports? ☐ Yes ☐ No How?: _____

Have you had any diagnostic tests or imaging performed regarding this complaint? ☐ Yes ☐ No

When: _____ Where: _____ Do you have copies?: ☐ Yes ☐ No

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MEDICATIONS:

Please list all medications that you are currently prescribed including over the counter medications:

1) _____ Dosage: _____
2) _____ Dosage: _____
3) _____ Dosage: _____
4) _____ Dosage: _____
5) _____ Dosage: _____

Please list any sensitivities or allergies that you are aware of:

1) _____
2) _____
3) _____
4) _____
5) _____

PERSONAL MEDICAL HISTORY:

Injuries/Accidents/Traumas: (e.g. Broken wrist 6/15/12)

Injury: _____ Injury: _____

Date: _____ Date: _____

Injury: _____ Injury: _____

Date: _____ Date: _____

Surgeries: (e.g. Left ACL Sept/2009)

Procedure:_____ Procedure:_____

Date: _____ Date: _____

Illnesses: (e.g. Diabetes circa 1998, ongoing)

Illness: _____ Illness: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

FAMILY MEDICAL HISTORY:

	Heart Disease	Cancer	Neurological (i.e. MS)	Other Major Ailments
Father's Side:	( ) _____ Age of onset	( ) _____ Age of onset	( ) _____ Age of onset	_____
Mother's Side:	( ) _____ Age of onset	( ) _____ Age of onset	( ) _____ Age of onset	_____
Siblings:	( ) _____ Age of onset	( ) _____ Age of onset	( ) _____ Age of onset	_____

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REVIEW OF BODY SYSTEMS:

Musculoskeletal -

Osteoporosis:	__ have	__ had	Arthritis:	__ have	__ had
Scoliosis:	__ have	__ had	Neck Pain:	__ have	__ had
Back Problems:	__ have	__ had	Hip Disorders:	__ have	__ had
Knee injuries:	__ have	__ had	Foot/ankle pain:	__ have	__ had
Shoulder Problems:	__ have	__ had	Elbow/wrist pain:	__ have	__ had
TMJ issues:	__ have	__ had	Poor posture:	__ have	__ had

Neurological -

Anxiety:	__ have	__ had	Depression:	__ have	__ had
Headaches:	__ have	__ had	Dizziness:	__ have	__ had
Pins & needles:	__ have	__ had	Numbness:	__ have	__ had

Cardiovascular -

High Blood Pressure:	__ have	__ had	Low Blood Pressure:	__ have	__ had
High Cholesterol:	__ have	__ had	Poor circulation	__ have	__ had
Angina:	__ have	__ had	Excessive bruising:	__ have	__ had

Respiratory -

Asthma:	__ have	__ had	Apnea:	__ have	__ had
Emphysema:	__ have	__ had	Hay fever:	__ have	__ had
Shortness of breath:	__ have	__ had	Pneumonia:	__ have	__ had

Gastrointestinal -

Anorexia/bulimia:	__ have	__ had	Ulcer:	__ have	__ had
Food sensitivities:	__ have	__ had	Heartburn:	__ have	__ had
Constipation:	__ have	__ had	Diarrhea:	__ have	__ had
I.B.S.	__have	__had	Crohns:	__have	__had

Sensory -

Blurred vision:	__ have	__ had	Ringing in ears:	__ have	__ had
Hearing loss:	__ have	__ had	Chronic ear infection:	__ have	__ had
Loss of smell:	__ have	__ had	Loss of taste:	__ have	__ had

Integumentary -

Skin cancer:	__ have	__ had	Psoriasis:	__ have	__ had
Eczema:	__ have	__ had	Acne:	__ have	__ had
Hair loss:	__ have	__ had	Rash:	__ have	__ had

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Endocrine-					
Thyroid issues:	__ have	__ had	Immune disorders:	__ have	__ had
Hypoglycemia:	__ have	__ had	Frequent infection:	__ have	__ had
Swollen glands:	__ have	__ had	Low energy:	__ have	__ had

Genitourinary-					
Kidney stones:	__ have	__ had	Infertility:	__ have	__ had
Bedwetting:	__ have	__ had	Prostate issues:	__ have	__ had
Erectile dysfunction:	__ have	__ had	PMS symptoms:	__ have	__ had

Constitutional -					
Fainting:	__ have	__ had	Low libido:	__ have	__ had
Poor appetite:	__ have	__ had	Fatigue:	__ have	__ had
Sudden weight gain/loss	__ have	__ had	Weakness:	__ have	__ had

SOCIAL HISTORY:

Current Smoker: ☐ yes ☐ no Years smoked: _____

Consumption:

How much alcohol do you drink daily?: _____ How much caffeine do you drink daily?: _____

How much soda pop do you drink daily?:_____ How much water do you drink daily?:_____

How much do you depend on pain relievers?: _____ How often do you use recreational drugs?:_____

Stress Information:

How much physical stress are you under?: not much – 0 1 2 3 4 5 6 7 8 9 10 – a lot

How much emotional stress are you under?: not much – 0 1 2 3 4 5 6 7 8 9 10 – a lot

What are the major stressors in your life: _____

Sleeping Information:

How many hours do you sleep per night?:_____ How well do you sleep?: ☐ Well ☐ Alright ☐ Not Well

What is your preferred sleeping position: ☐ Back ☐ Left side ☐ Right side ☐ Stomach

Healthy Eating & Exercise Information:

How often and what type of exercise do you perform?: _____

Rate your healthy eating habits: not healthy – 0 1 2 3 4 5 6 7 8 9 10 - healthy

Typical eating habits: ☐ Skip breakfast ☐ 2 meals per day ☐ 3 meals per day ☐ Snack between meals

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What would be the most significant thing that would improve your health?: _____

_____

_____

What additional health goals do you have?: _____

_____

_____

RECEIPT OF PRIVACY PRACTICES

By signing below, you acknowledge receipt of the Notice of Privacy Practices of RED-ROSE Chiropractic Clinic. You are also authorizing our clinic to use and disclose the health and medical information for the purposes of treatment, payment, and health care operations.

Signature of patient/guardian: _____ Date: _____

Please include the names of persons with whom we are allowed to discuss your condition and/or billing information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____