# RED-ROSE CHIROPRACTIC CLINIC, P.S.

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


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

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

Address: _____City, State:_____ Zip Code:_____

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

Preferred contact Method: ☐ home phone ☐ cell phone ☐ work phone ☐ email

Date of Birth: _____ Email: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ widowed

Emergency Contact: _____ Phone: (____)_____

Employer:_____ Occupation: _____

Name of primary care physician: _____

**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

**Smoking Status:** ☐ non-smoker ☐ former smoker ☐ current smoker

**Height: _____** **Weight: _____**

## FAMILY HISTORY OF DISEASES AND ILLNESSES:

| | Heart Disease | Cancer | Neurological (i.e. MS) | Other |
|---|---|---|---|---|
| Father's Side | ( ) | ( ) | ( ) | _____ |
| Mother's Side | ( ) | ( ) | ( ) | _____ |
| Siblings | ( ) | ( ) | ( ) | _____ |

## 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) _____

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## PRESENT CONDITIONS

**Primary Complaint:** **Date of Onset:**

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing
Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant Frequent Intermittent Occasional
(100%-75%) (75%-50%) (50%-25%) (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)
1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)
Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)
Rest Chiropractic Care Medication Movement Ice Heat

**Secondary Complaint:** **Date of Onset:**

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing
Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant Frequent Intermittent Occasional
(100%-75%) (75%-50%) (50%-25%) (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)
1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)
Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)
Rest Chiropractic Care Medication Movement Ice Heat

**Tertiary Complaint:** **Date of Onset:**

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing
Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant Frequent Intermittent Occasional
(100%-75%) (75%-50%) (50%-25%) (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)
1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)
Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)
Rest Chiropractic Care Medication Movement Ice Heat

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**Other Complaint:** **Date of Onset:**

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing
Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant (100%-75%) Frequent (75%-50%) Intermittent (50%-25%) Occasional (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)

1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)

Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)

Rest Chiropractic Care Medication Movement Ice Heat

**Have you had any of the following recently occur?: (check all those that apply)**

□ recent illnesses □ recent falls / accidents □ surgeries

□ changes in work habits/status □ changes in diet/nutrition

## REVIEW OF BODY SYSTEMS:

**Have you had any issues in following areas?: (PLEASE CIRCLE)**

**musculoskeletal** – osteoporosis, scoliosis, back problems, knee injuries, shoulder problems, TMJ, arthritis, neck pain, hip disorders, foot/ankle pain, elbow/wrist pain, poor posture

**neurological** – anxiety, headaches, pins & needles, depression, dizziness, numbness

**cardiovascular** – high blood pressure, high cholesterol, angina, low blood pressure, poor circulation, excessive bruising

**respiratory** – asthma, emphysema, shortness of breath, apnea, hay fever, pneumonia

**digestive** - ulcer, heartburn, diarrhea, constipation, food sensitivities, anorexia/bulimia

**sensory** - blurred vision, hearing loss, loss of smell/or taste, ringing in ears, chronic ear infection

**integumentary**- skin cancer, eczema, hair loss, psoriasis, acne, rash

**endocrine**- thyroid issues, hypoglycemia, swollen glands, immune disorders, frequent infection, low energy

**genitourinary** - kidney stones, bedwetting, infertility, prostate issues, PMS symptoms, erectile dysfunction

**constitutional** - fainting, poor appetite, sudden weight gain/loss, fatigue, weakness, low libido