

State Street Family Chiropractic

9414 State Ave., Suite G • Marysville, WA 98270 • (360) 653-6010

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions. Thank You.

Name:			Date:		
Address:			Home Phone:		
City, State:			ZIP:		
Birth Date:	Age:	Sex: M F	Social Security #:		
Marital Status: M W D S		Spouse's Name:			
Children's Names & Ages:					
Referred by:					
Employed by:			Occupation:		
Address:			Work Phone:		
Who is financially responsible for this bill?					
Method of Payment: (Check One) <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Insurance					

List your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the pain? _____

Does the pain spread? Yes No If yes, where? _____

Do you have numbness? Yes No If yes, where? _____

Is there pain when you cough or sneeze? Yes No If yes, where? _____

Is there pain when you go from a sit to a stand? Yes No If yes, where? _____

Do you have any headaches? Yes No If yes, circle all that apply:

Tension Throb Sinus Migraine Other: _____

Indicate any function below that aggravate or are aggravated by your condition: (Circle all that apply)

Walking Step Climbing Driving Working Working Recreation Bowel Movements Digestion
Vision Breathing Sinuses Hearing Smelling Sleeping If Female, Menstrual

Have you ever been to a chiropractor before? Yes No If yes, when? _____

List other doctors that were consulted for these conditions:

1. _____
2. _____

Previous diagnosis given: _____

List operations you have had:

1. _____
2. _____
3. _____

List serious illnesses you have had:

1. _____
2. _____
3. _____

Date of last physical examination: _____ Is there any chance you are pregnant? Yes No

Have you ever been diagnosed with cancer? Yes No If yes, what kind? _____

Medication you currently take: _____

Father, Mother, Brother, Sister, Children with similar problems? Yes No If yes, who: _____

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., TB, Hepatitis.

OVER 

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released. Copies may be made if necessary. The fee for these copies is \$10.00

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with

and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature

Date

Guardian's Signature Authorizing Care for Minor

Date

In case of emergency, please notify: _____
Name of nearest relative not living with you

Relationship

Address

Phone