BELLINGHAM CHIROPRACTIC CENTER, INC. P.S.

"Established 1973"

Date:_____

Dear Patient: Welcome to our office. The following information is considered confidential. We need this because we care enough to want to know, and your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank You

Name:_____ Home Phone :_____
Cell Phone:_____ E- Mail _____
Address:_____ Zip Code_____
Age:_____ Sex:_____ Birth Date:_____ S.S. # _____ Marital Status : S M D W
# of Children _____Ages: _____
Occupation: _____ Employer: _____
Employer Address:_____ Phone:_____
Name of Spouse:_____ Occupation: _____
Employer:_____# of yrs employed _____
Name of Insurance Company:_____
Insurance Coverage/Policy details: _____
Were you referred to this office? _____ By Whom: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Bellingham Chiropractor Center 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 Bellingham Chiropractic Center 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. *I understand I will be charged 12% annual service charges on overdue balance*

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Name of person responsible for payment: _____

Signature: _____

In case of emergency please contact_____Phone:_____
Address:_____Other Phone:_____

HEALTH HISTORY

Present Complaint and Symptoms:_____
Date Present Complaint Began:_____ Accident ( ) Auto ( ) Home ( ) Work ( )
Briefly Describe: _____
Have you had treatment by another Dr. for this:_____ Type: M.D. ( ) D.O. ( ) D.C. ( )
Name of Doctor: _____ Address: _____
Diagnosis:_____ Treatment: _____
Results: _____ Length of time under his/her care: _____

PAST HISTORY:

Have you had similar accidents or injuries before? _____ Describe: _____
Have you had any operations? _____ Type and date of each: _____
_____
Have you ever broken any bones? _____ What and When: _____
Have you ever been knocked unconscious? _____ How and When; _____

Have you ever been in a traffic accident? _____ Date and description:_____
_____

Are you taking any medicine? _____ Prescribed ( ) Over the Counter ( )

Have you taken any of the following?	Past	Present	Past	Present
	( )	( ) Aspirin	( )	( ) Laxatives
	( )	( ) Sleeping Pills	( )	( ) Sedatives
	( )	( ) Insulin	( )	( ) Birth Control Pills

Have you ever consulted a Doctor of Chiropractic before? _____ When: _____

Name of Doctor _____ Problem _____

HEALTH QUESTIONAIRE:

Have you had trouble with the following?

Musculo-Skeletal System

Past	Present	
( )	( )	Low Back problems
( )	( )	Pain between
( )	( )	Neck problem
( )	( )	Arm problems
( )	( )	Leg problems
( )	( )	Swollen joints
( )	( )	Painful joint
( )	( )	Stiff joints
( )	( )	Sore Muscles
( )	( )	Weak muscles
( )	( )	Walking problem
( )	( )	Ruptures
( )	( )	Broken bones

Genito-Urinary System

Past	Present	
( )	( )	Bladder trouble
( )	( )	Excessive urine
( )	( )	Scanty urination
( )	( )	Painful urination
( )	( )	Discolored urine

Female

Are you pregnant? _____

( )	( )	Vaginal discharge
( )	( )	Vaginal bleeding
( )	( )	Vaginal pain
( )	( )	Breast pain
( )	( )	Lumps on breast
( )	( )	Cramps Menstrual

Gastro-Intestinal System

Past	Present	
( )	( )	Poor Appetite
( )	( )	Excessive hunger
( )	( )	Difficult chewing
( )	( )	Difficult swallowing
( )	( )	Excessive Thirst
( )	( )	Nausea
( )	( )	Vomiting food
( )	( )	Vomiting blood
( )	( )	Abdominal pain
( )	( )	Diarrhea
( )	( )	Constipation
( )	( )	Black stool
( )	( )	Bloody stool
( )	( )	Hemorrhoids
( )	( )	Liver Trouble
( )	( )	Gall bladder trouble
( )	( )	Weight Trouble

Eye, Ears, Nose & Throat

( )	( )	Eye Strain
( )	( )	Eye inflammation
( )	( )	Vision problems
( )	( )	Ear pain
( )	( )	Ear noises
( )	( )	Hearing loss
( )	( )	Ear discharge
( )	( )	Nose pain
( )	( )	Nose bleeding
( )	( )	Nose discharge
( )	( )	Difficult breathing thru nose
( )	( )	Sore gums
( )	( )	Dental problems
( )	( )	Sore mouth
( )	( )	Confusion
( )	( )	Hoarseness
( )	( )	Depression
( )	( )	Difficult Speech
( )	( )	Allergies

Cardio-Vascular Respiratory

( )	( )	Chest Pain
( )	( )	Pain over heart
( )	( )	Difficult breathing
( )	( )	Persistent cough
( )	( )	Coughing phlegm
( )	( )	Coughing blood
( )	( )	Rapid heartbeat
( )	( )	Blood Pressure Problems
( )	( )	Heart problems
( )	( )	Lung problems
( )	( )	Varicose veins

Nervous System

( )	( )	Numbness
( )	( )	Loss of feeling
( )	( )	Paralysis
( )	( )	Dizziness
( )	( )	Fainting
( )	( )	Headaches
( )	( )	Muscle jerking
( )	( )	Convulsions
( )	( )	Forgetfulness

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