



# CONFIDENTIAL PATIENT INFORMATION

**PACIFIC CHIROPRACTIC CLINIC • 7503 196TH St. SW • Lynnwood, WA 98036**

TO ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL OF THE QUESTIONS

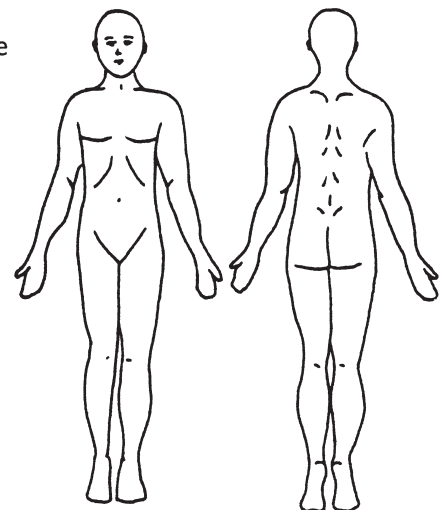
NAME	SEX <input type="checkbox"/> F <input type="checkbox"/> M	OCCUPATION	DATE OF BIRTH	AGE	TODAY'S DATE
ADDRESS		CITY	STATE		ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL	BEST PLACE TO REACH YOU: HOME, WORK, CELL PHONE, OR EMAIL? PLEASE CIRCLE	
EMERGENCY CONTACT			PHONE		
REFERRED TO THIS OFFICE BY:			WOULD YOU LIKE TO RECEIVE OUR EMAIL NEWSLETTER?		

## CURRENT HEALTH CONDITION

1. Purpose of this appointment: \_\_\_\_\_
2. When did this condition begin? \_\_\_\_\_
3. Is condition due to an injury?     Yes     No  
     If yes, was it     Job related     Auto related     Other-please explain \_\_\_\_\_
4. Other doctors seen for this condition: \_\_\_\_\_
5. Is this condition interfering with your     Work?     Sleep?     Recreation?
6. Have you had any spinal x-rays in the last year?     Yes     No    Dr.'s Name: \_\_\_\_\_  
     If yes, was it for the same problem?     Yes     No
7. Have you been to a chiropractor before?     Yes     No    Dr.'s Name: \_\_\_\_\_  
     If yes, was it for the same problem?     Yes     No    Did you receive good results?     Yes     No  
     Date of last adjustment: \_\_\_\_\_
8. I prefer to see:     Dr. Brian O'Hea     Dr. Susan Felber     No preference

Please indicate if you are currently experiencing any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Low back pain                  | <input type="checkbox"/> Cold/tingling extremities |
| <input type="checkbox"/> Pain between shoulders         | <input type="checkbox"/> Fatigue                   |
| <input type="checkbox"/> Neck pain                      | <input type="checkbox"/> Allergies                 |
| <input type="checkbox"/> Arm pain                       | <input type="checkbox"/> Fever                     |
| <input type="checkbox"/> Joint pain/stiffness           | <input type="checkbox"/> Headache                  |
| <input type="checkbox"/> Walking problems               | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Difficult chewing/clicking jaw | <input type="checkbox"/> Stomach Problems          |
| <input type="checkbox"/> Numbness                       | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> Dizziness                      | <input type="checkbox"/> Confusion/depression      |



Please outline on the diagram the area of your discomfort.