PAST HEALTH HISTORY

1. Have you been treated for any health condition in the past year? ☐ Yes ☐ No

   If yes, please explain:_____

2. Please list any previous accidents or spinal injuries:

   A_____

   B_____

   C_____

3. Please check if you have or have had any of the following:

   ☐ Atherosclerosis ☐ Diabetes ☐ Fainting

   ☐ Transient ischemic attacks ☐ Heart disease ☐ Oral contraceptive use

   ☐ High blood pressure ☐ Stroke

4. Please rate your overall level of health: 1 2 3 4 5 6 7 8 9 10
   Poor Excellent

   Do you exercise? ☐ Yes ☐ No What type?_____ How often?_____

   Do you smoke? ☐ Yes ☐ No How much?_____

5. Rate your stress level: Low Medium High

6. Are you content with your present level of health? ☐ Yes ☐ No

   If not, what aspect would you like to change?:_____

   WOMEN ONLY

   Are you pregnant? ☐ Yes ☐ No

   Date of last menstrual period:_____

   ☐ PMS ☐ Irregular cycle ☐ Unable to get pregnant

FINANCIAL RESPONSIBILITY

YOU ARE RESPONSIBLE FOR YOUR BILL, PLEASE CHECK THE APPROPRIATE CATEGORY BELOW

☐ CASH	☐ PERSONAL/GROUP HEALTH INSURANCE	☐ AUTO INSURANCE
☐ MEDICARE	☐ STATE INDUSTRIAL	

Please have our staff photocopy your insurance card or claim information.

Assignment of Benefits

I hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to Pacific Chiropractic Clinic. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance company.

PATIENTS/GUARDIANS SIGNATURE_____DATE_____

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 ☐ F ☐ 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: _____

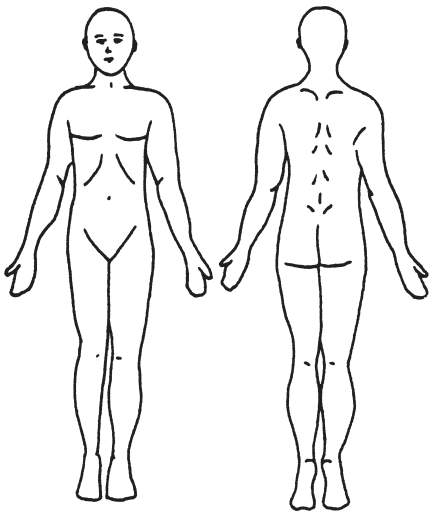
   If yes, was it for the same problem? ☐ Yes ☐ No
7. Have you been to a chiropractor before? ☐ Yes ☐ No Dr.'s Name: _____

   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:

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain/stiffness
- ☐ Walking problems
- ☐ Difficult chewing/clicking jaw
- ☐ Numbness
- ☐ Dizziness
- ☐ Cold/tingling extremities
- ☐ Fatigue
- ☐ Allergies
- ☐ Fever
- ☐ Headache
- ☐ Arthritis
- ☐ Stomach Problems
- ☐ Cancer
- ☐ Confusion/depression



Please outline on the diagram the area of your discomfort.