

**Fitzpatrick Chiropractic Clinic**  
 465 Rainier Blvd. North, Issaquah, Washington 98027  
 Phone: 425-392-5321

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Soc. Sec. No. \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Cell ph# \_\_\_\_\_ Pager# \_\_\_\_\_ Fax# \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital: M S W D How many children? \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Spouse's name \_\_\_\_\_ Spouse's birthday \_\_\_\_\_ Spouse's Soc. Sec. No. \_\_\_\_\_  
 Spouse's employer \_\_\_\_\_ Work phone \_\_\_\_\_  
 Insured 's name if patient is a dependent \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
 Insured 's employer \_\_\_\_\_ Work phone \_\_\_\_\_  
 Brief Job Description \_\_\_\_\_  
 Patient's nearest relative(not living with you) \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_

Please state your health problems in order of severity:

- \* Describe their **SEVERITY** on a scale from 0 to 10, with 0 being No Pain and 10 being the worst pain you have ever experienced
- \* Describe the **CHARACTER** of your pain, i.e., constant, burning, sharp, dull stabbing, throbbing, etc.
- \* **HOW LONG** have you had each problem?

Problem (s)	Severity	Character	How long?
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____

What do you expect to gain from initiating Chiropractic care?

\_\_\_\_\_

Is your current condition the result of an accident?  Yes  No  
 If yes,  Work related  Auto accident  Other \_\_\_\_\_

Date of injury? \_\_\_\_\_

What days have you lost from work? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes

Have you had a similar condition before?  Yes  No

If yes, please explain: \_\_\_\_\_

Is this condition interfering with your:  Work  Sleep  Daily routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Sleeping position:  Stomach  Side  Back

Have you seen other Doctors for this condition  Yes  No

If yes, please list: \_\_\_\_\_

If yes, did your condition  Totally Improve  Partially Improve  Worsen  Remain the same

What do you believe is wrong with you? \_\_\_\_\_

What operations have you had? \_\_\_\_\_

Describe: \_\_\_\_\_

Are you pregnant?  Yes  No Date of onset last menstrual cycle? \_\_\_\_\_

Please check the appropriate box for any of the following symptoms you are now experiencing or have had previously.

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 15 Rainier Blvd. N. • P.O. Box 658  
 Bannock, Washington 99027  
 (425) 262-5321

**THIS IS A CONFIDENTIAL HEALTH REPORT**

KEY	
<input type="radio"/> O	Occasional
<input type="radio"/> F	Frequent
<input type="radio"/> C	Constant

- O F C GENERAL**
- Allergy
  - Convulsions
  - Dizziness
  - Fainting
  - Headache
  - Neuralgia
  - Numbness

**MUSCLE & JOINT**

- Arthritis
- Back pain (lower)
- Back pain (upper)
- Bursitis
- Neck pain/stiffness
- Pain between shoulders
- Shoulder pain/numbness
- Arm pain/numbness
- Elbow pain/numbness
- Hand, wrist pain/numbness
- Hip pain/numbness
- Leg pain/numbness
- Knee pain/numbness
- Foot, Ankle pain/numbness
- Sciatica
- Swollen joints

**Drugs/Medications you are presently taking:**

- Nerve Pills
- Musculo relaxers
- Tranquilizers
- Diuretics
- Other: \_\_\_\_\_
- Pain killers
- "PEP" pills
- Insulin
- Birth control pills

- O F C GASTRO-INTESTINAL**
- Colon trouble
  - Constipation
  - Diarrhea
  - Difficult digestion
  - Distension of abdomen
  - Gallbladder trouble
  - Hemorrhoids
  - Liver trouble
  - Stomach pain

**EYES/EARS/NOSE THROAT**

- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Ear noise
- Eye pain
- Nasal obstruction
- Nosebleeds
- Sinus infection

**CARDIO-VASCULAR**

- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

- O F C RESPIRATORY**
- Chest pain
  - Chronic cough
  - Difficult breathing
  - Spitting up blood
  - Spitting up phlegm
  - Wheezing

**SKIN**

- Bruise easily
- Dryness
- Eruptions/rash
- Varicose veins

**GENITO-URINARY**

- Bad-wetting
- Bladder problems
- Blood in urine
- Frequent urination
- Kidney problems
- Painful urination
- Prostrate problems
- Pus in urine

**FOR WOMEN ONLY**

- Breast problems
- Cramps or backache
- Menstrual problems
- Hot flashes
- Irregular cycle
- PMS syndrome
- Menopausal symptoms
- Vaginal problems

**Date of last:**

- Physical Exam \_\_\_\_\_
- Spinal Exam \_\_\_\_\_
- Spinal X-ray \_\_\_\_\_
- Chest X-ray \_\_\_\_\_
- Blood test \_\_\_\_\_
- Urine test \_\_\_\_\_

Are you insured?  Yes  No Insurance company: \_\_\_\_\_

Name of person responsible for payment? \_\_\_\_\_

How do you intend to pay for today's visit?  Cash  Check  Credit Card?

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or spouse's signature authorizing care \_\_\_\_\_ Date \_\_\_\_\_