NORTHWEST CHIROPRACTIC

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

Today's Date ______________________ Cell Phone_____________

Name ____Female___ Male____Home Phone___________

Address____ City____________ State____ Zip__________

Age_____________________ Birthdate________________ Marital Status S M W D No. of Children_____________

Please circle one payment type: Cash Check Credit Card Flex Account Email Address: ______________________

Your Employer ___________________________________ Occupation ___________________ Years on Job _____

Employer Address __________________________________ City____________________ State____ Zip _________

Office Phone______________________________________ SS #_______________ Driv Lic # __________________

Insurance Company ____

Name of Spouse ____ Birthdate ______________________

Employer Address __________________________________ City____________________ State____ Zip _________

Spouse employed by ____ Occupation ____________ Years on Job _____

Office Phone______________________________________ SS #_______________ Driv Lic # __________________

Does your spouse have health Insurance at work Yes ___ No ___ Plan/Group # ________________________________

Describe the Major Complaints that bring you to our office ____

____

Is your condition due to an accident? Yes __ No __ Date of Accident ____

Type of accident? Auto ___ Work/On Job___ At Home___ Other ____

Have you ever been in an Auto Accident? Past Year _______ Past 5 years _______ Over 5 Years______ Never______

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.
I, the undersigned, hereby authorize Dr. Kart and whomever she may designate as her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Patient's Signature____ Date __________________

Spouse or Guardian's Signature____ Date __________________

As a courtesy, we offer text message reminders would you like to Opt In ____________________ or Opt Out ______________________

Please check yes or no for all listed below.

Y	N	CARDIOVASCULAR
		general swelling
		swelling in legs
		swelling in face
		swelling around eyes
		chest pain
		pounding heart beat
		heart "jumps"
		rapid heart beat
		blue or purple skin
		blue or purple nailbeds
		Fainting
		hypertension
		VERTEBROBASILAR
		double vision
		loss of coordination
		irregular muscle movement
		ringing in ears
		heart attack
		high blood pressure
		irregular heart beat
		hardening of the arteries
		areas of muscle weakness
		dizziness with nausea
		dizziness without nausea
		blurred vision
		fainting spells
		Stroke
		Diabetes
		pain over the heart
		cold hands and/or feet
		areas of numbness
		arthritis of the neck
		previous neck or head injury
		loss of memory
		inability to form words (speak plainly)
		periods of blindness in one eye
		areas of abnormal sensations such as burning, etc
		areas of numbness
		blood vessel disease (phlebitis, etc)
		check if you smoke
		check if any of your family members have had a stroke
		currently taking birth control pills

Y	N	MUSCULOSKELETAL SYSTEM HEAD
		unusually frequent headache
		unusually severe headache
		head feels heavy
		vertigo
		light-headedness
		loss of smell
		loss of taste
		loss of balance
		dizziness
		NECK
		pain in neck
		neck pain with movement
		swelling in neck
		neck feels out of place
		muscle spasms in neck
		limited neck movement
		SHOULDERS
		pain in shoulders (R-L)
		tension in shoulders
		muscle spasms in shoulders
		can't raise arm above shoulder
		ARMS & HANDS
		pain in upper arm
		pain in forearm
		pain in hands
		sensation of pins & needles
		in arms
		in fingers
		fingers go to sleep
		swollen joints in fingers
		sore joints in fingers

Y N		MID BACK
		mid back pain
		pain between shoulder blades
		sharp stabbing pain
		pain over kidney area
		muscle spasms in mid back
		LOW BACK
		low back pain
		low back feels out of place
		muscle spasms in low back
		HIPS, LEGS, AND FEET
		pain in buttocks
		pain down leg
		knee pain
		pins & needles in legs
		numbness in leg
		numbness in toes
		cold feet
		swollen ankles
		swollen feet

Please list current medications:
____
____
____
____

Please list all surgeries:
____
____
____

Name :______________________

Date:________________________

Please check yes or no for all listed below.

Y	N	SKIN HAIR NAILS
		eczema
		itchy skin
		dry scalp
		oil scalp
		rough, scaly skin
		dry skin
		oily skin
		psoriasis
		yellow skin
		bruise easily
		paper thin nails
		pale skin
		nail biting
		baldness
		EYES
		blurring of vision
		double vision
		eyes fatigue easily
		excessive tearing
		lack of tearing
		light bothers eyes
		excessive itching
		pain in eyeball
		EARS
		loss of hearing
		pain in ears
		discharge from ears
		vertigo
		ringing in ears
		NOSE AND SINUSES
		unusual nasal discharge
		nose bleeds
		pressure over eyes
		pressure under eyes
		obstruction of nose
		frequent colds
		sinusitis
		nasal allergies
		loss of sense of smell
		any trauma to nose
		MOUTH AND THROAT
		pain of mouth
		pain of throat
		bleeding gums
		cavities
		abscessed teeth
		dentures
		difficulty swallowing
		changes in voice

Y	N	RESPIRATORY
		shortness of breath
		can't breathe while lying down
		can't sleep while lying down
		dry cough
		productive cough
		coughing up blood
		wheezing
		GASTROINTESTINAL
		poor appetite
		constant nibbling
		difficulty in swallowing
		indigestion
		can't eat some foods
		nausea & vomiting
		jaundice
		abdominal pain
		change in bowel habits
		diarrhea
		constipation
		hemorrhoids
		GENITOURINARY
		urination is ( ) frequent
		( ) normal
		( ) infrequent
		the amount is ( ) high
		( ) normal
		( ) low
		need to get up at night to urinate
		abnormal intense desire to urinate
		difficulty starting urination
		decreased output
		pain on urination
		dribbling
		blood in urine
		cloudy urine
		lack of bladder control
		abdominal pain
		HIV
		AIDS
		syphilis
		gonorrhea
		other
		painful period
		spotting
		vaginal discharge
		premenstrual symptoms
		irregular periods
		lumps in breast
		# pregnancies ________
		# deliveries ________

Y N		SOCIAL HISTORY
		smoking
		other tobacco use
		alcohol use
		drink coffee or tea
		diet is: ( ) balanced
		( ) not balanced
		rest is: ( ) sufficient
		( ) not sufficient
		recreation is: ( ) sufficient
		( ) insufficient
		my family stress is: ( ) severe
		( ) moderate
		( ) minimal
		( ) none
		how do you like your work?
		( ) I like it very much
		( ) It's okay
		( ) I hate it
		my job stress is ( ) severe
		( ) moderate
		( ) minimal
		( ) none
		nervousness
		irritability
		fatigue
		depression
		generally feel run-down
		crave sweets
		crave salt

Name ________________________

Date _________________________