Interurban Chiropractic Center

13028 Interurban Ave S. Suite 106
Tukwila, WA 98168

Name _____Sex M F Date_____

Address_____City_____State_____Zip_____

H. Phone_____ W. Phone_____ Cell Phone _____

Date of Birth_____Age_____ Marital Status M S D W P Social Security #_____

Email address: _____Referred by: _____

Occupation_____ Employer_____

Insurance Company _____ ID#_____ Group#_____

Name of Insured: _____ Your relationship to Insured: _____

Emergency Contact _____1st Phone_____ 2nd Phone_____

Were you injured on the job? YES NO **Were you injured in an automobile accident? YES NO**

If yes to either of the above questions, please see the front desk for the appropriate intake form.

Purpose of this appointment: _____

_____

Is there any pain present? (No complaint / pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain / Emergency)

How frequent is complaint present? _____How long does it last? _____

Does anything aggravate the complaint? _____ Does anything make it better? _____

Please circle the type of the complaint/pain: dull achy sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness, tingling, burning or weakness in your body? Where? _____

Have you lost any days from school/work? YES NO Dates: _____

Have you had this problem before? YES NO If so, when? _____ Is this condition: Worsening - Staying the Same - Improving

Have you consulted other doctors for this condition? YES NO Names and Dates:_____

_____

Please check all that apply*:*

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Loss of Balance
- ❒ Buzzing in Ears

Please list any other Injuries, Traumas, Broken Bones and Surgeries you have had in the past, include dates:

_____

_____

Are you taking any medications or supplements? Please list:_____

Date of your last physical exam: _____ Height: _____ Weight: _____ Date of last chiropractic exam: _____

Females: Date of last menses: _____ Is there a possibility you could be pregnant? YES NO Please initial: _____

Any previous pregnancies? YES NO Any associated complications? Please list _____

_____

Do you have any Allergies? YES NO Please list: _____

Family Health History:

Health problems of relatives: _____

Cause of parents or siblings death: Age at death

_____ _____

_____ _____

6. *Social and Occupational History:*

A. Please describe your daily job duties:_____

B. What is your typical work schedule? _____

C. Recreational activities: _____

D. Please list your level of exercise, alcohol consumption, tobacco use and drug use:_____

_____

Assignment and Release:

I have answered the questions on this form truthfully and to the best of my knowledge. I hereby authorize the doctors at Interurban Chiropractic Center to provide me with chiropractic care in accordance with this state's statutes. I understand and agree that all services rendered to me are my financial responsibility and any health or accident insurance policies which I hold are based on a contract between the carrier and myself. I also understand that I am financially responsible for all non-covered services. I assign to Interurban Chiropractic Center my insurance benefits and authorize this office to use my personal information in accordance with its privacy practices, which were presented to me with this form.

Patient or Guardian Signature _____**Date**_____