LAKE STEVENS CHIROPRACTIC CLINIC
PATIENT HEALTH RECORD

ABOUT THE PATIENT

Name: First______________Initial____Last___________________

Address:_______________________________________

City______________________ State_____Zip___________

Date of Birth:______________Age:______Gender ☐ M ☐ F

Home Phone:_______________Cell Phone:______________

Work Phone:_______________Occupation:______________

Employer:_____________________________________

Driver's License #_______________________________

Social Security #________________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced

☐ Widowed ☐ Separated ☐ Other/Living together

E-Mail Address:_________________________________

Free Monthly Newsletter: ☐ yes ☐ no

SPOUSE/PARENT/INSURED INFO

Name:____

Employer:_______________Occupation:______________

Work Phone:_____________Cell Phone:_______________

Insurance Holder Name____________________________

Birthdate: __________Relationship to patient___________

EXPERIENCE WITH CHIROPRACTIC

How did you hear about our office? ☐ Phone Book ☐ Paper

Patient referral (name)________________________________

Other referral source__________________________________

Have you been adjusted by a chiropractor before?________

Reason for those visits:_______________________________

Doctor's Name:_______________________________________

Approximate Date of Last Visit:_________________________

REASON FOR TODAY'S VISIT

What is the purpose of today's visit?__________________

____

How long have you had this condition?_________________

Is this due to: ☐ **on the job injury** ☐ **car accident?**

Is this condition ☐ Getting better? ☐ Getting worse?

☐ Staying the same? What does this condition prevent

you from doing? ☐ Sleep ☐ Standing ☐ Sitting ☐ Walking

☐ Lifting ☐ Work ☐ Household chores ☐ Other________

Have you had this condition before? ☐ Yes ☐ No

Other Doctors or Health Care Providers seen for this

condition:_____________________________________

Type of Treatment given:__________________________

What were the Results?___________________________

MEDICATIONS & VITAMINS

Please list ALL Medications or Vitamins you take:_________

____

LIFESTYLE HABITS

Height:________ Weight:_______ Dominant Hand:________

Exercise: ☐ Seldom ☐ ______X per week ☐ Daily

Servings of Fruits & Vegetables you eat per day?________

Do you smoke or use tobacco? ☐ No ☐ Yes ______day

Do you drink alcohol? ☐ No ☐ Yes _____X per week

Do you use products containing Aspartame? ☐ No ☐ Yes

Do you wear orthotics or shoe inserts? ☐ No ☐ Yes

FAMILY HISTORY

Digestion Problems ☐ Yes ☐ No who: ____________

Asthma ☐ Yes ☐ No who: ____________________

Heart Disease ☐ Yes ☐ No who: _______________

Thyroid ☐ Yes ☐ No who : _____________________

Allergies ☐ Yes ☐ No who : ____________________

Stroke/TIA ☐ Yes ☐ No who : _________________

Sinus Problems ☐ Yes ☐ No who : _________________

Osteoporosis ☐ Yes ☐ No who : ___________________

Hepatitis ☐ Yes ☐ No who : _____________________

Infectious Disease ☐ Yes ☐ No who : _______________

Arthritis ☐ Yes ☐ No who : __________________

Psychiatric Problems ☐ Yes ☐ No who : ____________

Alcohol/Drug Abuse ☐ Yes ☐ No who : _____________

HIV/AIDS ☐ Yes ☐ No who : __________________

Kidney Problems ☐ Yes ☐ No who : _________________

Diabetes ☐ Yes ☐ No who : ____________________

Cancer ☐ Yes ☐ No Who : ___________Type:___________

Who : _______________ Type: ________________

Who : _______________ Type: ________________

SURGERIES

Spinal ☐ Sinus ☐ Tonsils ☐ Throat ☐

Thyroid ☐ Colon ☐ Stomach ☐ Appendix ☐

Gallbladder ☐ Hysterectomy ☐ Other ___________

WOMEN ONLY

Pregnant? ☐No ☐Yes Nursing? ☐No ☐Yes

Do you take oral birth control? ______ Do you have painful periods? _____ Do you have irregular cycles?______

Do you have breast implants? ________Year_________

PRIOR INJURIES

Have you broke any bones? What_____________How_____________Year____ What_____________How___________ Year____

Have you ever been involved in a car accident (even a minor one) ☐ Yes ☐ No When:_________ Type? ___________________

Did you receive any treatment? ☐ Yes ☐ No What?____

GOALS FOR CHIROPRACTIC CARE

☐ **"PATCH CARE"** Symptomatic Relief of your pain or other symptoms

☐ **"FIX CARE"** Correcting the underlying cause of your symptoms and problems with Chiropractic care

☐ **COMPREHENSIVE CARE** Work to bring the function of the body to its highest level with Chiropractic care

☐ **WELLNESS CARE** Bringing the body to its optimum state of health & well being with Chiropractic care

AUTHORIZATION FOR CHIROPRACTIC CARE

I hereby authorize Lake Stevens Chiropractic Clinic, Dr. Gaddis, or whomever they may authorize to work with my condition through the use of chiropractic adjustments and any necessary ancillary care as is deemed appropriate. I agree that I will not hold Lake Stevens Chiropractic Clinic, Dr. Gaddis responsible for any pre-existing medically diagnosed condition(s) nor for any medical (non-chiropractic) diagnosis. Any X-Rays taken of my spine are permanent records of Lake Stevens Chiropractic Clinic, Dr. Gaddis, and will remain on file in accordance to State Law.

Patient Signature:____ Date:______________________________

(Parent or legal guardian if patient is under 18 years old. Please PRINT your name and relationship to patient in space below.)