

SWEET CHIROPRACTIC INC PS

3535 MARTIN WAY E
OLYMPIA, WA 98506
360.455.3272

Welcome!

ABOUT YOU...

DATE _____

NAME: _____ M.I. _____ M / F I PREFER TO BE CALLED: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____ SSN: _____ HEIGHT: _____ WEIGHT: _____

PHONE(S): HOME: _____ CELL: _____ WORK: _____

REFERRED BY: _____ EMPLOYER: _____

OCCUPATION / JOB DESCRIPTION: _____ EMAIL: _____

MARITAL STATUS: S M D SPOUSE'S NAME: _____ SPOUSE'S BIRTHDATE: _____

REASON FOR YOUR VISIT...

REASON FOR THIS VISIT IS A RESULT OF (PLEASE CIRCLE): WORK, SPORTS, AUTO, TRAUMA, CHRONIC

EXPLAIN WHAT HAPPENED: _____

DESCRIBE THE PAIN & ITS LOCATION: _____

WHEN DID THIS CONDITION BEGIN? _____

IS THIS CONDITION GETTING WORSE IN (CIRCLE): INTENSITY? FREQUENCY? DURATION?

RATE YOUR PAIN (1-10): HEADACHE _____ NECK _____ MIDBACK _____ LOWBACK _____

IS THIS CONDITION INTERFERING WITH YOUR (CIRCLE): WORK? SLEEP? DAILY ROUTINE?

HAVE YOU BEEN TREATED FOR THIS CONDITION BY ANY OTHER DOCTOR? YES / NO

IF SO, WHERE? _____ WHEN? _____ BY WHOM? _____

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE? YES / NO HOW LONG AGO? _____

EMERGENCY CONTACT...

WHOM SHOULD WE CONTACT? _____ RELATION: _____

PHONE(S): HOME: _____ CELL: _____ WORK: _____

INSURANCE INFO...

NONE

COMPANY NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURED'S SSN: _____ INSURED'S DOB: _____ POLICY / PLAN / GROUP #: _____

INSURED'S EMPLOYER: _____

PLEASE LET US COPY YOUR INSURANCE CARD AND INFORM US OF 2ND INSURANCE SOURCE.
INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT. COVERAGE DEPENDS ON ELIGIBILITY AND PLAN PROVISIONS.

HEALTH HISTORY...

PATIENT NAME _____

PLEASE LIST ANY PRESCRIPTION OR OTC MEDICATIONS: _____

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (CIRCLE)

HEADACHES

NECK PAIN

NUMBNESS / TINGLING

DIZZINESS / FAINTING

MID BACK PAIN

ARM / LEG PAIN

LOW BACK PAIN

HIP PAIN

OTHERS _____

CHEST PAIN

DIFFICULTY BREATHING

HIGH/LOW BLOOD PRESSURE

HIV / AIDS

CANCER

ASTHMA

ARTHRITIS

ARTIFICIAL JOINTS

SEIZURE / EPILEPSY

HEART CONDITION

LIVER CONDITION

HEPATITIS

KIDNEY CONDITION

FREQUENT URINATION

DIABETES

FIBROMYALGIA / CHRONIC FATIGUE

LIST PREVIOUS SURGERIES/TRAUMAS/HOSPITALIZATIONS: _____

LIST PAST ACCIDENTS: _____

DO YOU USE TOBACCO? YES / NO HOW MUCH? _____ HOW LONG? _____

DO YOU USE ALCOHOL? YES / NO HOW MUCH? _____ HOW LONG? _____

WOMEN: BIRTH CONTROL? YES/NO PREGNANT? YES/NO HOW LONG? _____ LAST MENSES: _____

TO AID IN THE EVALUATION OF YOUR CONDITION, PLEASE MARK THE AREAS INVOLVING YOUR PAIN WITH THE FOLLOWING KEY:

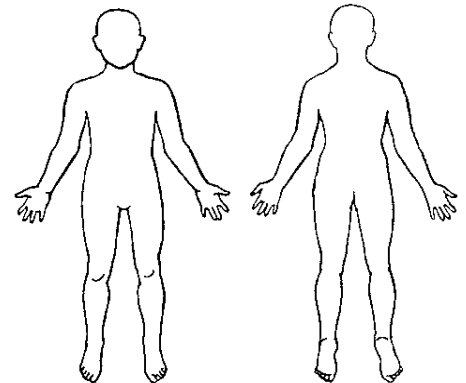
P FOR PAIN

B FOR BURNING

A FOR ACHING

S FOR STABBING

N FOR NUMBNESS / TINGLING



WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.

OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IF ACCOUNT IS NOT PAID WITHIN A REASONABLE TIME AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT.

WE WILL ATTEMPT TO BILL YOUR INSURANCE OR RESPONSIBLE PARTY AS A COURTESY, HOWEVER, YOUR ACCOUNT IS YOUR RESPONSIBILITY.

I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

I AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED.

I UNDERSTAND THAT ALTHOUGH CHIROPRACTIC CARE HAS BEEN PROVEN TO BE SAFE AND EFFECTIVE, THERE ARE RISKS WITH ALL TYPES OF CARE. THESE RISKS MAY INCLUDE, BUT ARE NOT LIMITED TO, AGGRAVATION OF PAIN, TEMPORARY SORENESS, OR INEFFECTIVENESS.

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH OR PERSONAL STATUS.

SIGNATURE: _____ DATE: _____