

NEW PATIENT INTAKE

Owens Chiropractic P.S 32123 1st Ave S., Suite A-3, Federal Way, WA 98003 (P) 253-831-4637

PERSONAL INFORMATION

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____
Date of Birth: _____ Age: _____ Sex: M F
SSN: _____ Marital Status: _____
E-Mail: _____

Employer: _____ Occupation: _____
Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____
Relationship: _____ Address: _____

Health Insurance Company Name: (1) _____ (2) _____
ID #: (1) _____ (2) _____
Policy Holder Date of Birth: _____ Policy Holder SSN: _____

How Were You Referred to this Office?

Allow me to say thank you to your friends or family members who referred you!

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CURRENT HEALTH CONDITION

Primary Complaint: _____
When Did It Happen? _____
Where Did It Happen? _____
How did It Happen? _____

Current Illnesses: Cancers: _____ Diabetes: _____
Osteoporosis/ Osteopenia: _____ High Blood Pressure: _____
Hypothyroidism/ Hyperthyroidism: _____ Hyperparathyroidism: _____
Auto Immune Diseases: _____ Pregnancy _____
Weight Issues: _____ Other: _____
Heart Disease: _____

Height: _____ Weight: _____

PAST HEALTH HISTORY:

Past Surgeries: _____
Date of Surgeries: _____
Broken Bones (when broken): _____

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Previous Car Accidents: _____

Previous L&I Injuries: _____

Hospitalizations: _____

Prior Chiropractic Care: _____

Current Medication List:

Please Circle any of the disease you may have had in the past:

- Anemia Pneumonia Mumps Measles Rubella Flu
- Whooping cough Rheumatic Fever Tuberculosis Diabetes Cancer
- Epilepsy Depression Anxiety Bipolar Eczema Asthma
- Chicken Pox Tetanus Shortness of Breath

Have your tested POSTIVE for HIV? _____

MUSCULOSKELETAL ISSUES (Please Circle All That Applies)

- Sacral/ TailboneLow Back Upper Back Pain Neck Pain Headaches
- Migraines Leg Pain Rt/ Lt Arm Pain Rt/ Lt Walking Problems Jaw Problems
- Muscle Weakness Numbness Tingling Cold Extremities Swollen Joints
- Hand Pain Foot Pain Paralysis Pain with inhalation Tremors Fatigue/ Sleep

NERVOUS SYSTEM

- Anxiety Depression Forgetfulness Stress Seizures Vertigo Concussion

CARDIOVASULAR

- Abnormal Rhythm Chest Pain Shortness of Breath Lung Problems Poor Circulation

EARS/ EYES/ NOSE and THROAT

- Allergies Earaches Tinnitus Sinusitis Asthma Blurred Vision
- Sore Throat Low Grade Fever

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GASTRO-INTESTINAL

IBS w/ Diarrhea/ Constipation Poor/ Excessive Hunger Vitamin/ Mineral Mal-Absorption
Nausea Vomiting Diarrhea Constipation GERD

GENITO-URINARY (Males)

Painful Urination Excessive Thirst Excessive Urination Bed Wetting Prostate

Sexual Dysfunction

GENITO-URINARY (FEMALES)

Menstrual Irregularity Heavy Bleeding Breast Pain/ Lumps Severe Cramping

Inability to Conceive PCOS Sexual Dysfunction Pregnancy

FAMILY HEALTH HISTORY

Mother and Mother’s Family:

Diabetes _____ Heart Disease _____ Cancer _____ Bone Health _____ Autoimmune _____

What health condition did they suffer from and did they pass from it?

Father and Father’s Family:

Diabetes _____ Heart Disease _____ Cancer _____ Bone Health _____ Autoimmune _____

What health condition did they suffer from and did they pass from it?

Anything Else You Can Think Of?

I understand and agree that health and accident insurance policies are an agreement between the carrier and myself. Furthermore, I understand that the Doctor’s 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 the Doctor’s office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I

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am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services will be immediately due and payable. I also understand that I will not be billed for services, copays, or co-insurance percentages or payments towards my deductible that is due at time of service. I hereby authorize the doctor of chiropractic to provide care to my neuromuscular/ skeletal system that she has deem appropriate. It is understood and agreed that the amount pain to the doctor for an x-ray examination and the negatives will remain the property of the office. The patient also agrees that he/she is responsible for all bills incurred at this office. I understand that all copays, deductibles payments or co-insurance is due at time of service.

Patient Signature _____

Date: _____