

Redmond Ridge Chiropractic

23525 NE Novelty Hill Road, STE 109 Redmond, WA 98053, 425-868-0120,
www.redmondridgechiropractic.com

About You:

Today's Date: _____ Soc Sec#: _____

Last Name: _____

First Name: _____ M.I. _____

Mailing Address: _____

City: _____ State _____

Zip _____ DOB: ____ / ____ / ____ Age: _____

Race: _____ Language: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____ Carrier _____

Email: _____

What's best way to contact you? Home Phone Work Phone

Cell Phone (Voice) Cell Phone (Text) E-Mail

Referred By: _____

Occupation: _____

Since: ____ / ____ / ____ (Date)

Status: Single Married Divorced Widowed

Spouse's Name: _____

Children: No Yes How Many? _____

Children's Names:

Chiropractic History:

Have you had Chiropractic Care before? Yes No

If yes, please explain the reason for the visits, and your experience:

Doctor's Name: _____

Approx. Date of last visit ____ / ____ / ____

Would you like us to contact them regarding your care?

Yes No Phone number: _____

Physicians:

Primary Physician:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Type of Physician: _____

Other Physicians:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Type of Physician: _____

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Type of Physician: _____

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Type of Physician: _____

Emergency Contact:

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

PLEASE CONTINUE ON OTHER SIDE

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Health History:

Are you currently taking any medications or supplements?

Medication/Supplement	Dosage/Frq	Medication/Supplement	Dosage/Frq

Please check the box next to any condition you have **OR HAVE HAD IN THE PAST:**

	Condition	Date Diagnosed		Condition	Date Diagnosed
<input type="checkbox"/>	Severe or frequent Headaches		<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Frequent Neck Pain		<input type="checkbox"/>	Digestive Problems	
<input type="checkbox"/>	Pain Between the Shoulders		<input type="checkbox"/>	Loss of Sleep	
<input type="checkbox"/>	Numbness/Pain in the Arms/Legs		<input type="checkbox"/>	Psychiatric Problems	
<input type="checkbox"/>	Low Back Pain		<input type="checkbox"/>	Seizures/Epilepsy	
<input type="checkbox"/>	Respiratory Problems		<input type="checkbox"/>	High/Low Blood Pressure (circle one)	
<input type="checkbox"/>	Congenital Heart Defect		<input type="checkbox"/>	Sinus Problems	
<input type="checkbox"/>	Heart Murmur or Arrhythmia		<input type="checkbox"/>	Dizziness	
<input type="checkbox"/>	Ulcers/Colitis		<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	Kidney Problems		<input type="checkbox"/>	HIV/Aids	
<input type="checkbox"/>	Tuberculosis		<input type="checkbox"/>	Anemia	
<input type="checkbox"/>	Alcohol/Drug Abuse		<input type="checkbox"/>	Heart Attach/Disease/Congestive Failure	
<input type="checkbox"/>	Rheumatic Fever		<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	Emphysema		<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Artificial Bones/Joints/Implants		<input type="checkbox"/>	Hepatitis Type: _____	
<input type="checkbox"/>	Thyroid Disease		<input type="checkbox"/>	Arthritis Type: _____	
<input type="checkbox"/>	Glaucoma		<input type="checkbox"/>	Cataracts	

Please List Any Additional Illnesses:

Illness	Date	Illness	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Please List Any Allergies you have:

Allergy	Date of last episode	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List Any Surgeries you've had:

Surgery	Date	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol Use: _____ (drinks/day) **Caffeine Use:** _____ (drinks/day) **Exercise:** _____ (Frequency)

Drug Use – Recreational Addiction Daily, Weekly

Do You Smoke? YES Packs/Day: _____ FORMER SMOKER NO

Are you wearing: Shoe Lifts Inner Soles Arch Supports or Orthotics Heel Lifts

If you checked any of the above – when did you start wearing them (approximate date): _____

When they were last checked for fit (approximate date): _____

Women Only: Are you taking Birth Control? Yes No Are you Nursing? Yes No

Are you Pregnant? Yes No If yes, how many weeks? _____ Do you experience painful periods? Yes No

Do you experience Irregular Cycles? Yes No Are you Breast Feeding? Yes No

Family History:

Family History: (please be specific – e.g. Maternal Grandmother) - Include Grandparents, Parents and Siblings.

Family Member	Disease	Deceased? (Y/N)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Current Problem List:

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Symptom #1: _____ 0 1 2 3 4 5 6 7 8 9 10

Frequency: _____% (% of waking hours)

Symptom #2: _____ 0 1 2 3 4 5 6 7 8 9 10

Frequency: _____% (% of waking hours)

Symptom #3: _____ 0 1 2 3 4 5 6 7 8 9 10

Frequency: _____% (% of waking hours)

Symptom #4: _____ 0 1 2 3 4 5 6 7 8 9 10

Frequency: _____% (% of waking hours)

Symptom #5: _____ 0 1 2 3 4 5 6 7 8 9 10

Frequency: _____% (% of waking hours)

Symptom #6: _____ 0 1 2 3 4 5 6 7 8 9 10

Frequency: _____% (% of waking hours)

When did your symptoms begin? _____

What was the cause of your symptoms? Auto Accident Work Injury Lifting Slip/Fall Overexertion

Strenuous Position Unknown Other _____

Approximate Onset Date: _____ Gradual Onset Sudden Onset

Work

How do your health problems make it harder to do your job? _____

Are you less productive on your job because of your health problems? Yes No

Are you concerned about your ability to do your job or the security of your job? Yes No

Please Explain _____

Social/Recreational

Have you had to modify your lifestyle in anyway due to this condition?

Authorization For Care:

I hereby authorize the Doctor and appointed staff to work with my condition through the use of chiropractic care, rehabilitation, nutrition, and other modalities agreed upon as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand payment in full for all services rendered is required in full at the time of service unless other arrangements have been made in advance. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I authorize the provider to release any information required to process insurance claims. I hereby authorize assignment of my insurance rights and benefits (if using insurance) directly to the provider for services rendered.

Patient's Signature

Date

Guardian or spouse's signature authorizing care

Date

Insured Person:

Relationship:

Employer:

DOB: