CONFIDENTIAL PATIENT INFORMATION

Name: ____ Marital Status (M S D W) Age: ____Birth Date:______/______/_______
Height: ________ Weight: ________ Sex (F M) Race: _______________ **Phone (H):** ___________________(**W**):___________________
Spouse's Name: ___________________Children: ______________________________ **SOCIAL SECURITY #:** _____-____-________
Address (Street, City, State, Zip): ____
Medical Doctor:___________________________________
EmailAddress:____**Cell#:**_____________________________
Occupation: ______________________________ How Long: ________ Employer:_____________________________________
Referred by: _______________________________________Previous Chiropractic Care:_____________________________________
ACCIDENTS: Please describe, give date, injuries, broken bones, fractures, treatment
Automobile:____
Occupational:____
Recreational:____
Childhood:____
Operations/Surgeries (type/date): ____
X-Rays (date, where taken, of what, findings)____

PRESENT COMPLAINT: ____ How Long?: ____________ Is it constant?:_______
How did it occur?: _____________________________________ What relieves it?: ____

Please check the symptoms you have noticed:

☐ Headache	☐ Dizziness/Faintness	☐ Eye/Vision Problems	☐ Cold Feet
☐ Neck Pain/Stiff	☐ Loss of Smell	☐ Arm/Shoulder Pain	☐ Chest/Rib Pain
☐ Upper Back Pain	☐ Loss of Taste	☐ Pins/Needles Arms	☐ Problems Breathing
☐ Low Back Pain	☐ Problems Sleeping	☐ Finger Numbness	☐ Coughing
☐ Pressure in Head	☐ Fever/Chills	☐ Cold Hands	☐ Stomach Upset
☐ Loss of Balance	☐ Fatigue/Depression	☐ Leg/Hip Pain	☐ Bowel Problems
☐ Ear Ache/Ringing	☐ Nervousness	☐ Pins/Needles Toes	☐ Indigestion
☐ Irritability	☐ Stress/Tension	☐ Numbness in Toes	☐ Urination Problems

Symptoms not listed above:
____
Other doctors seen for this condition:
____
What medications are you taking:
____
Health Questions:
Do you smoke? _____ Drink alcoholic beverages? _____ Eat a well-balanced diet?______Sleep 6-8 hours? _____Daily Exercise?_____

NO SYMPTOMS EXTREME SYMPTOMS
1____10
Place an "X" on the line above to indicate the level of the problem.

PLEASE LIST ANY AND ALL INSURANCE COVERAGE WHICH MAY BE APPLICABLE IN THIS CASE:
Primary Insurance Company: _________________________________ Secondary Insurance Company: ___________________________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient or Guardian's Signature: ____**Date:** _______________________

INFORMED CONSENT

PATIENT NAME ____

Clinic Name 180° Chiropractic Wellness Center, LLC

Doctor's Name Dr. Joshua Ebert

Address 111 W. North River Drive Suite 202 Spokane, WA 99201

Phone 509-315-8758 Fax 509-315-8944

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain side effects that can occur as a result of a spinal manipulation. These include, but are not limited to: dizziness, nausea, muscle strain and swelling. In rare cases, complications include disc and vertebral injury, fractures, strains and dislocations. The most common symptom or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these symptoms/complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE ______________________

____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if a minor)

FAMILY HISTORY

PATIENT NAME ____

DATE ____________________ Doctor__________________________

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient ____

Signature of Patient/Legal Guardian ____

Date ____

Office Use Only
☐ 1
☐ 4-5
☐ >5

Patient #:____________________

Pain Drawing

Name:____________________________________ Date:__________________________

Date of Birth:______________________________ Examiner:_______________________

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it start to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache = A
Burning = B
Numbness =N
Stabbing = S
Pins & Needles = PN
Throbbing = T