PATIENT INFORMATION

NAME: _____ Date of Birth: _____ Today's Date:_____

Social Security #:_____ Age: _____ E-mail: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Check if you are: ❒ Single ❒ Married ❒ Significant Other ❒ Divorced ❒ Separated ❒ Widowed
If a minor - Name of Parents:_____
What is Your Occupation?_____ Employer:_____
Work Address:_____
Name of Spouse:_____ Ages of Children:_____
Where is Your Spouse (or parent) Employed?:_____
Who referred you or how did you learn of our office?_____

YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. FOR BALANCES WITH NO PAYMENTS FOR 30 DAYS, 1% MONTHLY INTEREST WILL BE CHARGED. DEPENDING OF YOUR INSURANCE, WE CAN BILL YOUR INSURANCE FOR REIMBURSEMENT.

How payment is made: ____ Cash ____Visa, MC or Debit Card ____Auto Insurance
____ Check ____ Health Insurance ____ Worker's Comp (L&I)

Name of Insurance Company:_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION: I authorize the release of health or other information necessary to process this claim. I authorize payment of medical and/or government benefits to Calcara Family Chiropractic.
❒ **CONSENT TO TREAT A MINOR**: As the parent or legal guardian of the above patient, I authorize Calcara Family Chiropractic to examine and administer treatment as deemed necessary to my child.

Signed:_____ Date:_____

CALCARA FAMILY CHIRORPRACTIC, PS 1946 4th Ave. East Olympia, WA 98506 (360) 352-3333

HEALTH HISTORY QUESTIONNAIRE

Calcara Family Chiropractic, PS ♦ 1946 4th Ave E ♦ Olympia, WA 98506 ♦ (360) 352-3333

NAME: _____ **DATE:** _____ **AGE:** _____

Which best describes your usual approach to your health care?

❒ I wait until I'm in really bad shape, then I want a miracle. ❒ I seek relief of symptoms only.
❒ I try to prevent problems from developing. ❒ I take active steps to try to stay healthy.
❒ I actively pursue wellness in all areas of my life.

What is your reason for coming to this office? _____
_____

If due to auto or work accident: Injury Date _____ **Briefly describe incident:** _____
_____

Your Main Complaint – What body area bothers you? _____

- Describe your complaint or pain:_____
- When and how did this begin? _____
- How often do you feel this? ❒ Constantly ❒ Off and on, daily ❒ Occasionally
  ❒ When I do the following:_____
- How severe is this problem normally (0-10) _____ , and at its worst? (0-10) _____
- Does it radiate to any other body areas? _____
- What makes it worse? _____
- What makes if lessen? _____
- How does this affect your ability to do things (home, work, sleep, recreation, etc.)? _____
- _____
- _____
- What have you tried for this condition, and what results did you get? _____
  _____

Other Complaints – What other areas bother you? _____

- Describe your complaint or pain:_____
- When and how did this begin? _____
- How often do you feel this? ❒ Constantly ❒ Off and on, daily ❒ Occasionally
  ❒ When I do the following:_____
- How severe is this problem normally (0-10) _____ , and at its worst? (0-10) _____
- Does it radiate to any other body areas? _____
- What makes it worse? _____
- What makes if lessen? _____
- How does this affect your ability to do things (home, work, sleep, recreation, etc.)? _____
- _____
- _____
- What have you tried for this condition, and what results did you get? _____
  _____

What do you expect in coming to this office? _____
_____

What is the best possible outcome you can imagine? _____
_____

(Please turn over and complete back side)

PAST HEALTH HISTORY Name: _____

Incidents that can affect your spinal health

Birth trauma: ❒ Difficult delivery ❒ Forceps ❒ Breach ❒ C-section ❒ Other _____

Childhood traumas - Please check all that apply and write your age at time of incident:

Falls while: ❒ Learning to walk ____ ❒ Riding bike ____ ❒ Riding horse ____ ❒ Other falls _____

Other traumas: ❒ Auto accidents ____ ❒ Fights/Abuse ____ ❒ Sports injuries _____

Major stresses: ❒ Death of loved one ____ ❒ Parental Divorce____ ❒ Major Illness in family _____

❒ Other _____

Adult traumas: ❒ Death of loved one _____ ❒ Divorce _____ ❒ Major Illness _____ ❒ Abuse _____

❒ Auto accidents _____ ❒ Sports injuries _____ ❒ Knocked unconscious _____

❒ Other _____

List any food, drug or environmental allergies: _____

When did you begin chiropractic care? ❒ This is the first time ❒ At Age_____ ❒ Lifelong patient

When did you last see a Doctor of Chiropractic? _____ Who? Where?_____

Type of Care: ❒ Relief ❒ Problem ❒ Maintenance ❒ Wellness. Results: _____

When did you last see a Medical Doctor? _____ Why? _____

Who is your Primary Health Care Provider? _____

How often do you go to the dentist? ❒ Every 6 months ❒ Yearly ❒ When in pain ❒ For dentures

Drugs you currently take: ❒ Pain killers ❒ Muscle relaxers ❒ Blood Pressure ❒ Blood thinners ❒ Insulin

❒ Anti-Depressants ❒ Birth Control ❒ Others _____

List all surgeries you've had (include the year): _____

_____

Females: Are you pregnant? ❒ Yes ❒ No Due Date: _____ OB/Midwife: _____

Healthy Habits:

Exercise: What do you do? _____ How often? _____

Sleep: How many hours per night?_____ What position(s)? ❒ Side ❒ Back ❒ Stomach

What vitamins do you take: _____ How often? _____

How many meals do you eat/day? _____ How often do you eat "fast food"? _____ times per week.

How much water do you drink? _____ glasses/day. How much coffee/soda? _____ /day.

What hobbies/recreation do you enjoy? _____

What type of work do you do? _____

Un-healthy Habits:

Tobacco use: ❒ None ❒ Past ❒ Current _____ packs/day.

Alcohol: ❒ None ❒ Past ❒ Current _____ per day/week/month.

Recreational drugs: ❒ None ❒ Past ❒ Current - Describe: _____

❒ Prolonged sitting (at computer, TV, in car, etc.) _____ hours/day ❒ Prolonged standing _____ hours/day.

Other bad habits you want to confess! _____

Please check any condition you have had in the past, and *circle any that are current*:

❒ Diabetes ❒ Asthma ❒ Anemia ❒ Eczema ❒ Vision Loss

❒ Hypertension ❒ Pneumonia ❒ Measles/mumps ❒ Depression ❒ Hearing Loss

❒ Heart Disease ❒ Thyroid ❒ Chicken Pox ❒ Mental Disorder ❒ PMS

❒ Heart Attack ❒ Epilepsy ❒ Shingles ❒ Rheumatic Fever ❒ Digestive Disorders

❒ Stroke ❒ Arthritis ❒ HIV/AIDS ❒ Incontinence ❒ Large weight gain/loss

❒ Cancer - where/type and year:_____

Are there any other health problems or concerns the doctor should know about? _____

_____

How would you describe your current level of health? _____

How healthy would you like to be? _____

What are you willing to do to improve your degree of health? _____

Patient (*or guardian*) Signature: _____ Date: _____