NEW PATIENT INTAKE

Owens Chiropractic P.S. 33650 6th Ave S. Suite 100 Federal Way, WA 98003 (P) 253-942-3300

PERSONAL INFORMATION

Name: _____ Address:_____
Home Phone: _____ City _____ State: _____Zip:_____
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!

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/ HYPERthyrodism:_____ HYPERparathyroidism: _____
Auto Immune Diseases: _____
Pregnancy:_____ Weight
Issues:_____ Other: _____
Heart Disease:_____ _____

Height:_____ Weight:_____

PAST HEALTH HISTORY:

Past Surgeries: _____
Date of Surgeries: _____
Broken Bones (when broken):_____
Previous Car Accidents: _____
Previous L&I Injuries: _____
Hospitalizations: _____

NEW PATIENT INTAKE

Owens Chiropractic P.S. 33650 6th Ave S. Suite 100 Federal Way, WA 98003 (P) 253-942-3300

Prior Chiropractic Care:_____
Current Medication List:
_____
_____
_____

Please Circle any of the diseases 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 you ever tested POSITIVE for HIV? _____

MUSCULOSKELETAL ISSUES (Please Circle All That Applies)

Sacral/ Tailbone Low 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 PoorCirculation

EARS/ EYES/ NOSE and THROAT

Allergies Ear Aches Tinnitus Sinusitus Asthma Blurred Vision

Sore Throat Low Grade Fever

GASTRO-INTESTINAL

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

Nausea Vomiting Diarrhea Constipation GERD

NEW PATIENT INTAKE

Owens Chiropractic P.S. 33650 6th Ave S. Suite 100 Federal Way, WA 98003 (P) 253-942-3300

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 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 payed 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, deductible payments or co-insurance is due at time of service.

Patient Signature _____ Date: _____