**Lake Washington Family Chiropractic**
**816 6th Street S**
**Kirkland, WA 98033**

Voice: 425-827-4646
Fax: 425-827-1941
Email: lakewashingtonfamilychiro@gmail.com

**PATIENT INFORMATION**

**Name:**_______________________________ **Preferred Name:**_______________
First MI Last

**Address:**____________________ **City:**__________ **State:**____ **Zip:**_______

**Home:**_________ **Cell:**_________ **Work:**_________ **Email:**_______________

**Gender:** Male Female **Date of Birth:**___/___/___ **Social Security #:**_______________

**Occupation:** Student Employed Unemployed Retired **Marital Status:** Single Married Divorced Widowed

**Employer:**____________________ **Spouse's Name:**____________________

**Position:**____________________ **Children:** Yes No NA **How Many:**_______

**How did you hear about our clinic?**______________________________

**EMERGENCY CONTACT INFORMATION**

**Name:**____________________ **Relationship:**____________________

**Home:**_________ **Cell:**_________ **Primary Care Physician:**_______________

**FORM OF PAYMENT**

Insurance Self-Pay (cash, check, credit card) Worker's Compensation Personal Injury or Auto

**Person Responsible for Payment:** Self Other (specify)

**Name:**____________________ **Relationship:**____________________

**Address:**____________________ **City:**__________ **State:**____ **Zip:**_______

**Primary Insurance:**____________________ **Secondary Insurance:**____________________

**Relationship to Insured:** Self Spouse Parent Other **Relationship to Insured:** Self Spouse Parent Other

_______
Initial

I hereby authorize assignment of my insurance rights and benefits directly to Lake Washington Family Chiropractic for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

**REASON FOR VISIT**

**Major Complaint:**______________________________

______________________________

**Date of Onset:**___/___/___

**Activity at Time of Onset:**______________________________

______________________________

**Type of Pain:** Achy Burning Dull Radiating Sharp

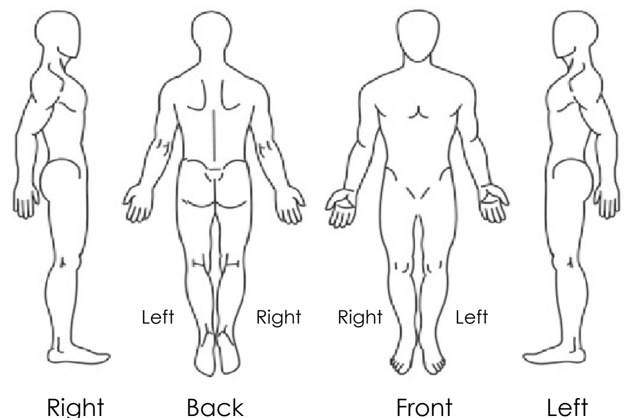
Sore Stabbing Stiff Other: _______

**Frequency:** Occasional Intermittent Frequent Constant

**Intensity:**______________________________

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | Moderate | | | Severe | | | Very Severe |

**Please Circle Areas of Complaint**



**Does anything alleviate pain?** Ice Heat Rest Movement Stretching Medication Other : ____________

**Does anything aggravate pain?** Sitting Standing Walking Lifting Lying Down Sleeping Other: ____________

**Describe activities affected by pain:** ____________________________________________

**Have you received any of the following for current condition?** Chiropractic Physical Therapy Massage Acupuncture Other: ____________________________________________

**Where and when?** ____________________________________________

**Have you had any diagnostic testing?** CT MRI X-ray **Where and when?** ____________________________

**Describe any surgical procedures performed for this condition:** ____________________________________________

---

**PATIENT HEALTH HISTORY:** Please check all that apply.

- **General**
  - Recent weight loss / gain
  - Fever
  - Fatigue
- **Skin**
  - Rash or itching
  - Change in skin color
  - Change in hair or nails
  - Non-healing sores
  - Change in appearance of mole(s)
  - Other: ____________________
- **Musculoskeletal**
  - Low back pain
  - Mid back pain
  - Neck pain
  - Arm problems
  - Leg problems
  - Painful, stiff, or swollen joints
  - Sore or weak muscles
  - Broken bones
  - Joint replacement
  - Other: ____________________
- **Neurological**
  - Numbness or tingling sensation
  - Loss of feeling
  - Dizziness or lightheadedness
  - Frequent or recurrent headaches
  - Convulsions or seizures
  - Tremors
  - Stroke
  - Head injury
  - Other: ____________________
- **Vision**
  - Glaucoma
  - Eye disease or injury
  - Other: ____________________
- **Ears, Nose, and Throat**
  - Tinnitus (ringing in ear)
  - Hearing loss
  - Allergies/sinusitis
  - Bleeding gums or mouth sores
  - Dental problems
  - Swollen throat or lymph glands
  - Other: ____________________
- **Endocrine/Hematologic/Lymphatic**
  - Thyroid problems
  - Diabetes
  - Excessive thirst or urination
  - Cold extremities (hands or feet)
  - Heat or cold intolerance
  - Glandular or hormonal problems
  - Anemia
  - Easily bruise or bleed
  - Immune system disorder (HIV+/AIDS)
  - Other: ____________________
- **Cardiovascular**
  - Chest pain
  - Irregular heartbeat
  - Pacemaker
  - Heart attack
  - Hypertension (high blood pressure)
  - Hypotension (low blood pressure)
  - Edema
  - Other: ____________________
- **Respiratory**
  - Difficulty breathing
  - Persistent cough
  - Asthma
  - Bronchitis
  - COPD
  - Emphysema
  - Other: ____________________
- **Gastrointestinal**
  - Loss of appetite
  - Change in bowel movements
  - Abdominal pain/ulcer/colitis
  - Frequent diarrhea/constipation
  - Other: ____________________
- **Genitourinary**
  - Sexual dysfunction
  - Incontinence or bed wetting
  - Frequent urination
  - Kidney stones
  - Other: ____________________
- **Reproductive**
  - Breast pain/lump
  - Painful or irregular menses
  - Infertility
  - Prostrate problems
  - Erectile dysfunction
  - Other: ____________________
- **Women Only**
  - Are you pregnant: Yes No
    - Due date: ________________
- **Psychological**
  - Stress
  - Anxiety
  - Nervousness
  - Depression
  - Sleep problems
  - Memory loss or confusion
  - Other: ____________________
- **Current Medications**
  - ____________________
  - ____________________
  - ____________________
  - ____________________
  - ____________________
  - ____________________

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with Washington State Statutes.

Patient or Guardian Signature ______________________________ Date ______________