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Health First Chiropractic
1519 9th Street
Suite 101
Marysville, WA 98270
360.658.1987

Patient Information:

Date			SSN	Birthday
First Name			Middle Name	Last Name
Sex	Male	Female	Height	Weight
Married/Civil Union:			Spouse Name	# of Children
Home #			Cell #	Work #
Address				
City			State	Zip
Emergency Contact			Emergency Relation	Emergency Phone
Email				

Patient Symptoms:

Ache / Dull
Sharp / Stabbing
Numb / Tingling
Pins & Needles
Burning
Throbbing
Cramping
Radiating
Other Pains

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Patient Social

Alcohol:	Daily	Weekly	Occasionaly	Never	Caffeine:	Daily	Weekly	Occasionaly	Never
Diet Food Products:	Daily	Weekly	Occasionaly	Never	Drugs:	Daily	Weekly	Occasionaly	Never
OTC Stimulants:	Daily	Weekly	Occasionaly	Never	Exercise:	Daily	Weekly	Occasionaly	Never
Homemade Food:	Daily	Weekly	Occasionaly	Never	Processed:	Daily	Weekly	Occasionaly	Never
Soft Drinks:	Daily	Weekly	Occasionaly	Never	Tobacco:	Daily	Weekly	Occasionaly	Never
Water:	Daily	Weekly	Occasionaly	Never					

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Chiropractic Experience:

Who referred you to our office:

Where did you hear about us? Newspaper Sign Yellow Pages Mailing Community Event Other

Have you been adjusted by a chiropractor before? Yes No If yes, Why?

Doctor's Name: Approximate Date of Visit

Has any member of your family ever seen a wellness chiropractor? Yes No

Employer Information:

Employed: Employer Name

Employer Address:

Employer City: Employer State: Employer Zip:

Occupation: Work Supervisor: Supervisor #:

Work Duties:

Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life.

Wellness Sports Auto Fall Home Injury Job Chronic Discomfort Other

Briefly Explain:

When did this concern begin? Has this concern: Gotten Worse Stayed Constant Come and Gone

Does this concern interfere with: Work Sleep Daily Routine Other Activities

Briefly Explain:

Has this concern occurred before? Yes No

Briefly Explain:

Have you seen other doctor's for this concern? Yes No Doctor's name:

Type of Treatment:

Results: Good Bad Indifferent

Personal Health History

Last Physical Exam: Primary Phys: Phys Phone #:

Phys City: Phys State: Phys Zip:

Health Conditions:

Previous Chiro Care: Yes No Date: Condition(s) treated:

Chance Pregnant: Yes No Planning: Yes No

Medications:

Supplements:

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Personal Incident History:

Broken Bones:	Yes	No	Treatment:	Yes	No	Explain
Sprains/Strains:	Yes	No	Treatment:	Yes	No	Explain
Hospitalized:	Yes	No	Explain:			
Surgery:	Yes	No	Explain:			
Auto Accident:	Yes	No	Treatment:	Yes	No	Explain
Struck Unconscious:	Yes	No	Treatment:	Yes	No	Explain
Eating Disorder:	Yes	No	Explain:			
Stroke:	Yes	No	Explain:			

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Health Checklist:

Alcoholism	Allergies	Anemia
Arteriosclerosis	Arthritis	Asthma
Autoimmune Disease	Back Pain	Bleeding Disorders
Breast Lump	Bronchitis	Bruise Easily
Cancer	Cataracts	Chest Pain
CHF	Cold Extremities	Constipation
COPD/emphysema	Cramps	CVA (stroke/TIA)
Dementia/Alzheimer's	Depression	Diabetes
Diagnosed emotional/mental	Digestion Problems	Dizziness
Epilepsy	Excessive Menstruation	Eye Pain or Difficulties
Fatigue	Frequent Urination	Gallbladder disease/stones
Glaucoma	Gout	Headache
Hemorrhoids	High Blood Pressure	Hot Flashes
Irregular Heart Beat	Irregular Menstrual Cycle	Kidney Infection
Kidney Stones	Liver disease/cirrhosis	Loss of Balance
Loss of Memory	Loss of Smell	Loss of Taste
Lung disease	Macular Degeneration	Migraines
Nosebleeds	Pacemaker	Parkinson's
Polio	Poor Posture	Prostate Trouble
Retinal Disease	Sciatica	Seizures
Shortness of Breath	Sinus Infection	Skin Sensitivity
Sleep Problems/Insomnia	Smoked	Spinal Curvatures
Stroke	Swelling of Ankles	Swollen Joints
Thyroid Condition	Tuberculosis	Ulcers
Varicose Veins	Venereal Disease	Other

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Have you had any of these Cardiovascular Diseases? Please select all that apply.

Myocardial infarction	Hypertension	Hypercholesterolemia
Bypass surgery	Coronary artery disease	

Do you have Diabetes? If so what type?

Type I   Type II   Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

Ulcers	Reflux	IBS

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Family Health History:

Family Health History

EHR Information:

Preferred Language Ethnicity Race

Smoking Status Smoking Start Date Tried to quit? Yes No

Type of Tobacco Cigarettes Chewing Tobacco Cigar Pipe Other

How much tobacco do you use? How long have you used tobacco?

Current Medications And Dosage

Medication Allergies

I choose to decline receipt of my clinical summary after every visit

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Signature Date:

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