Cornerstone Chiropractic

Thank you for choosing our practice for your Chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help! Please print clearly and fill in completely.

Name _____ **Nickname** _____ **Date** _____

Home Address_____ Apt. #_____

City_____ State_____ Zip_____Preferred Language_____

Home Phone_____Cell Phone_____Email_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Date of Birth_____ Age_____ ❑Male ❑Female ◆ ❑Single ❑Married ❑Divorced ❑Widowed

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I decline to answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I decline to answer

Student: ❑Full time ❑Part time ❑Non-student Social Security # _____

Employer_____Occupation_____❑Full time ❑Part time

Employer's Address_____City, State, Zip_____

Name of Spouse_____Spouse's Birth Date ___

Spouse's Employer_____Social Security#_____

Person to contact in case of Emergency: _____Phone _____

Medical Doctor Name and Clinic_____Phone_____

Would you like us to send your doctor an initial report of our Chiropractic findings? _____

How did you hear about our clinic?_____

Have you ever been to a Chiropractor before? ❑Yes ❑No If yes, Doctor's Name _____

Date of last Chiropractic Visit_____Reason for Care _____

Date of last Chiropractic X-rays_____How long were you under care? _____

Are other family members under Chiropractic care?_____

Reason for this visit: _____

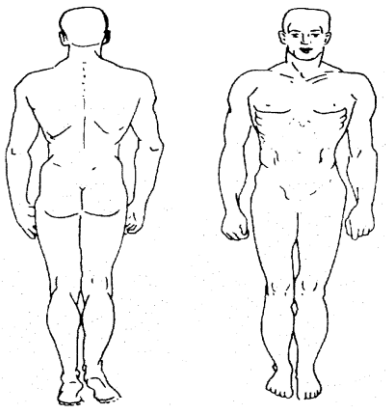
Is this related to: ❑Auto Accident ❑Employment Accident ❑Other Accident

Name and address of other doctor(s) who have treated you for this condition:_____

_____

Please mark the areas of your pain on the diagram below. Use the following letters to indicate the type and location of your pain.

A=Ache
B=Burning
P=Pain
S=Stabbing
N=Numbness
O=Other



Cornerstone Chiropractic ◆ Dr. Cameron Lichfield
2003 132nd Street SE, Suite E, Everett, WA 98208 (425) 379-6301

Review of Systems:

Check only those conditions that currently apply to you. **Underline** any conditions you have had in the past.

General:	❒ Weight loss/gain	❒ Fatigue	❒ Trouble sleeping	❒ Weakness
Skin:	❒ Skin condition	❒ Dryness	❒ Rashes/Itching	❒ Hair/nail changes
Head:	❒ Headache	❒ Migraine	❒ Head injury	❒ Concussion
Ears:	❒ Hearing loss	❒ Ear infection	❒ Ringing in ears	❒ Drainage
Eyes:	❒ Glasses/contacts	❒ Vision problems	❒ Pain/redness	❒ Blurry/double vision
Nose:	❒ Allergies	❒ Nosebleeds	❒ Sinus pain	❒ Congestion/itching
Throat:	❒ Sore throat	❒ Non healing sores	❒ Dry mouth	❒ Bleeding from mouth
Neck:	❒ Swollen glands	❒ Pain	❒ Stiffness	❒ Lumps
Respiratory:	❒ Shortness of breath	❒ Wheezing	❒ Painful breathing	❒ Cough/cough up blood
Cardiovascular:	❒ Heart Problems	❒ Palpitations	❒ Chest pain	❒ High blood pressure
Gastrointestinal:	❒ Abdominal pain	❒ Heartburn	❒ Hemorrhoids	❒ Constipation/Diarrhea
Genitourinary:	❒ Incontinence	❒ Female problems	❒ Sexual dysfunction	❒ Difficulty urinating
Musculoskeletal:	❒ Muscle or joint pain	❒ Muscle spasm	❒ Arthritis	❒ Swollen/red joints
Neurologic:	❒ Seizures	❒ Dizziness	❒ Weakness	❒ Numbness/tingling
Hematologic:	❒ Bruises easily	❒ Anemia	❒ Blood disorder	❒ Clotting problems
Endocrine:	❒ Change in appetite	❒ Sweating	❒ Frequent urination	❒ Heat/cold intolerance
Psychiatric:	❒ Depression/Anxiety	❒ Dizziness	❒ Nervousness	❒ Psychiatric disorder
Other:	❒ Allergies	❒ Frequent colds	❒ Disc problems	❒ Cold hands/feet
Other:	❒ Stroke	❒ Diabetes	❒ Cancer	❒ HIV/AIDS

Medical and Family History:

List current medications and the condition you are taking it for: (Include regularly used over the counter drugs)

Medication _____for_____Dose and freq._____

Medication _____for_____ Dose and freq._____

Medication _____for_____ Dose and freq._____

Medication Allergies/adverse reactions _____

List past surgeries and dates _____

List past accidents/traumas and dates _____

List any X-rays you have had in the last 2 years _____

List any diseases/conditions of family members (heart disease, stroke):_____

Females: Are you pregnant? ❑Yes ❑No Date of last period_____Birth control pills ❑Yes ❑No

Name and Age of Children_____

Social History and Daily Habits:

Do you sleep on your: ❑Back ❑Right Side ❑Left Side ❑Stomach

Do you exercise? ❑Yes ❑No Type of exercise_____Frequency _____

Smoking status (check one): ❑Every day smoker ❑Occasional smoker ❑Former smoker ❑Never smoked

Do you drink alcohol? ❑Yes ❑No Frequency and Amount_____

Do you drink coffee/tea/caffeinated beverages? ❑Yes ❑No Quantity _____

What do your daily work habits include? (Ex. sitting, standing, light labor, heavy labor, computer work)

_____

Hobbies: _____

I understand the above and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my health status.

Patient Signature _____Date_____

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