

# Cordata Chiropractic

Dr. Fred Neil, 4151 Meridian St., Ste. 102, Bellingham, WA 98226

Date: \_\_\_\_\_

**Dear Patient: Welcome to our office. The following information is considered confidential. We need this because we care enough to want to know, and your answers will help us determine if Chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ e-mail: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: M / F Birth Date: \_\_\_\_\_  
# of Children: \_\_\_\_\_ Ages: \_\_\_\_\_ Marital Status: S M D W  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Number of Years Employed: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Number of Years Employed: \_\_\_\_\_  
Insurance Coverage/Policy Details: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

Health and accident insurance policies are an arrangement between you and your insurance carrier. Cordata Chiropractic will prepare any reasonable reports and forms to assist you in making collection from the insurance company. Any amount authorized will be paid directly to Cordata Chiropractic, and will be credited to your account on receipt. However, all services rendered are charged directly to you and you are personally responsible for payment. If you suspend or terminate care and treatment, any fees for professional services rendered will be immediately due and payable.

**\* Payment Is Expected at the Time of Visit Unless Prior Arrangements Have Been Made \***

Name of person responsible for payment: \_\_\_\_\_

## **Health History:**

Present Complaint and Symptoms: \_\_\_\_\_

Date Present Complaint Began: \_\_\_\_\_ Accident: ( ) Auto ( ) Home ( ) Work

Briefly Describe: \_\_\_\_\_

Have you had treatment by another doctor for this? Y / N Type: ( ) M.D. ( ) D.O. ( ) D.C.

Name of Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment: \_\_\_\_\_

Results: \_\_\_\_\_ Length of time under care: \_\_\_\_\_

## **Past History:**

Have you had similar accidents or injuries before? Y / N Describe \_\_\_\_\_

Have you ever had any operations? Y / N Type and date of each: \_\_\_\_\_

Have you ever broken any bones? Y / N What and When: \_\_\_\_\_

Have you ever been in a traffic accident? Y / N Give date and description \_\_\_\_\_

Are you taking any medicine? Y / N ( ) Prescribed ( ) Over the counter

Have you taken any of the following?

Past	Present		Past	Present		Past	Present	
( )	( )	Aspirin	( )	( )	Laxatives	( )	( )	Blood Pressure Meds
( )	( )	Sleeping Pill	( )	( )	Sedatives	( )	( )	Cholesterol Meds
( )	( )	Insulin	( )	( )	Birth Control Pills			

Have you ever consulted a Doctor of Chiropractic before? Y / N When? \_\_\_\_\_

Name of Doctor \_\_\_\_\_ Problem \_\_\_\_\_

**Health Questionnaire:**

Have you had trouble with the following?

**Musculo-Skeletal System**

Past	Present	
( )	( )	Low back problems
( )	( )	Pain between shoulders
( )	( )	Neck problems
( )	( )	Arm problems
( )	( )	Leg problems
( )	( )	Swollen joints
( )	( )	Painful joints
( )	( )	Stiff joints
( )	( )	Sore muscles
( )	( )	Weak muscles
( )	( )	Walking problems
( )	( )	Ruptures
( )	( )	Broken bones

**Eye, Ear, Nose and Throat**

Past	Present	
( )	( )	Ear pain
( )	( )	Ear noises
( )	( )	Hoarseness
( )	( )	Difficult speech
( )	( )	Allergies

**Gastro-Intestinal System**

Past	Present	
( )	( )	Difficult chewing
( )	( )	Difficult swallow
( )	( )	Nausea
( )	( )	Abdominal pain
( )	( )	Diarrhea
( )	( )	Constipation
( )	( )	Hemorrhoids

**Family History**

Has anyone in your family been treated for the same or similar condition? Y / N

If yes, please explain \_\_\_\_\_

**Genito-Urinary System**

Past	Present	
( )	( )	Bladder trouble
( )	( )	Excessive urine
( )	( )	Scanty urine
( )	( )	Painful urine
( )	( )	Discolored urine

**Cardio-Vascular Respiratory**

Past	Present	
( )	( )	Chest pain
( )	( )	Pain over heart
( )	( )	Difficult breathing
( )	( )	Persistent cough
( )	( )	Rapid heart beat
( )	( )	Blood pressure problem
( )	( )	Heart problems
( )	( )	Lung problems

**Female**

Past	Present	
( )	( )	Menstrual cramps

Are you pregnant? Y / N

**Nervous System**

Past	Present	
( )	( )	Numbness
( )	( )	Paralysis
( )	( )	Dizziness
( )	( )	Fainting
( )	( )	Headaches
( )	( )	Muscle jerking
( )	( )	Convulsions
( )	( )	Confusion
( )	( )	Depression

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_