Seattle Life Chiropractic
Chiropractic Registration and History

Personal and Family Health History

Name _____ Referred By _____

Address _____ Occupation _____

City _____ State ____ Zip _____ Employer _____

Phone: (H) _____ Marital Status S M D W

Phone: (W) _____ Spouse's Name _____

(Cell) _____ Spouse's Occupation _____

E-mail _____ In case of Emergency, Contact

Date of Birth _____ Age _____ Name _____

Sex □ Male □ Female Relationship _____

Social Security #: _____ Phone: (H) _____

If Female, are you currently pregnant? Yes No Phone: (W) _____

Family Doctor _____ (Cell) _____

Have you been adjusted by a chiropractor before? Yes / No Date of last visit: _____

Fee Schedule:

Our experience has shown that it is wise to have an understanding with our patients as to our office fees and policies. The following is our professional fee schedule:

Basic office visit (adjustments)	$40-$49	Modalities	$25-$40
Re-examinations	$45-$210	Massage	$60-$120

Insurance: *(Please bring a copy of your card to your appointment)*

Relationship to Patient_____ Is patient covered by additional Insurance: Y N

Insurance Company _____ Subscriber's Name _____

Group # _____ ID # _____ Birth date _____

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Company _____

Group # _____ ID # _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Current Health Habits

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking — Packs/day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/ Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Do you take Vitamins? _____

Do you take Medications? _____

_____

Please list any injuries you have had (*Car accidents, falls, head injuries, broken bones etc)* Date

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgeries:

_____ _____
_____ _____
_____ _____

Current Health Condition

1. Present Complaint (be brief) Reason For Your Visit Today _____

Pain or Problem started on _____

Pains are: (select all that apply)
- ☐ Sharp ☐ Dull/Ache ☐ Burning
- ☐ Constant ☐ Intermittent ☐ Occasional
- ☐ Daily ☐ ___ times per Week/Month

Rate your pain on a Pain Scale:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

What activities aggravate your condition/pain? _____

_____

What activities lessen your condition/pain? _____

_____

Is condition worse during certain times of the day? _____

_____

Does this condition interfering with your
- ☐ Sleep ☐ Routine ☐ Work
- ☐ Recreation ☐ Other _____

Is this condition:
- ☐ getting progressively worse ☐ staying the same
- ☐ getting better ☐ Not sure

Other Doctors seen for this condition _____

_____

Any home remedies? _____

2. Second Complaint (be brief) Reason For Your Visit Today _____

Pain or Problem started on _____

Pains are:
- ☐ Sharp ☐ Dull/Ache ☐ Burning
- ☐ Constant ☐ Intermittent ☐ Occasional
- ☐ Daily ☐ ___ times per Week/Month

Rate your pain on a Pain Scale:
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

What activities aggravate your condition/pain? _____

_____

What activities lessen your condition/pain? _____

_____

Is condition worse during certain times of the day? _____

_____

Does this condition interfering with your
- ☐ Sleep ☐ Routine ☐ Work
- ☐ Recreation ☐ Other _____

Is this condition:
- ☐ getting progressively worse ☐ staying the same
- ☐ getting better ☐ Not sure

Other Doctors seen for this condition _____

_____

Any home remedies? _____

Other symptoms/Health Conditions:

- ☐ Headaches
- ☐ Sleeping Problems
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Pain b/t Shoulders
- ☐ Pins & Needles in Legs
- ☐ Pins & Needles in Arms
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Sinus Problems
- ☐ Dizziness/Loss of Balance
- ☐ Digestive Problems
- ☐ Ulcers/Colitis
- ☐ Cancer
- ☐ HIV/Aids /Venereal Disease
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Shingles
- ☐ Loss of Memory
- ☐ Kidney Problems
- ☐ Arthritis
- ☐ Congenital Heart Defect
- ☐ Heart Attack/Stroke
- ☐ Asthma/Allergies
- ☐ Thyroid Problems
- ☐ Anemia
- ☐ Hands/Feet Cold
- ☐ Hepatitis
- ☐ Psychiatric Problems
- ☐ Constipation/Diarrhea
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ High/Low Blood Pressure
- ☐ Alcohol/Drug Abuse
- ☐ Rheumatic Fever

Family history:

	Heart Disease	Arthritis	Cancer	Diabetes	Other	
Father's Side	☐	☐	☐	☐	☐	_____
Mother's Side	☐	☐	☐	☐	☐	_____

Seattle Life Chiropractic

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well being, not merely the absence of disease of infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
Signature Date