



# *GIG HARBOR CHIROPRACTIC & MASSAGE*

## **PATIENT HEALTH RECORD**

(FOR OFFICE USE ONLY)

NAME \_\_\_\_\_ DATE \_\_\_\_\_ CASE NUMBER \_\_\_\_\_

## *Welcome to our Wellness Center!*

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants. It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being via specific chiropractic care.

Please note that all information is strictly confidential.

To help us provide you with a complete evaluation take the time to fill out this questionnaire carefully. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. Thank you.

## ABOUT THE PATIENT

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Gender  M  F      Number of Children \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_

Type of Work \_\_\_\_\_

Marital Status     Married     Single     Divorced  
 Separated     Widowed

E-Mail Address \_\_\_\_\_

Social security # \_\_\_\_\_

Who is your primary care Physician?  
\_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Who referred you to our office?  
\_\_\_\_\_

Have you ever been adjusted by a  
Chiropractor before?     YES     NO

Reasons for those visits?  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Name \_\_\_\_\_

Approximate date of your last visit  
\_\_\_\_\_

*Your Health Is  
Our Passion!*

*We Hope We Can  
Help you!*

## ABOUT THE SPOUSE/ PARENT OR EMERGENCY CONTACT

Name \_\_\_\_\_

Employer \_\_\_\_\_

Work/Cell Phone \_\_\_\_\_

Type of Work \_\_\_\_\_

## AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

- ...Doctors of Chiropractic specialize in the nervous system?       Yes     No
- ...The nervous system controls all functions of the body?       Yes     No
- ...Chiropractic is the largest natural healing profession in the world?       Yes     No
- ...If chiropractic care starts at birth, you can achieve a higher level  
of health throughout your life?       Yes     No

*The doctor of the future will give no medicine but will interest his patients in the care  
of the human frame, in diet and in the cause and prevention of disease.*

~Thomas Edison



## HEALTH COMPLAINTS

**Reason #1 for contacting our office:** \_\_\_\_\_

mild    moderate    severe    ~    Please rate your complaint on a scale 0-10 \_\_\_\_/10  
(0 being no symptoms)  
 constant    intermittent

symptoms ↑ with activity                      symptoms ↓ with activity

Date of Injury: \_\_\_\_\_

If no injury, when did this problem begin? \_\_\_\_\_

**Reason #2 for contacting our office:** \_\_\_\_\_

mild    moderate    severe    ~    Please rate your complaint on a scale 0-10 \_\_\_\_/10  
(0 being no symptoms)  
 constant    intermittent

symptoms ↑ with activity                      symptoms ↓ with activity

Date of Injury: \_\_\_\_\_

If no injury, when did this problem begin? \_\_\_\_\_

**Reason #3 for contacting our office:** \_\_\_\_\_

mild    moderate    severe    ~    Please rate your complaint on a scale 0-10 \_\_\_\_/10  
(0 being no symptoms)  
 constant    intermittent

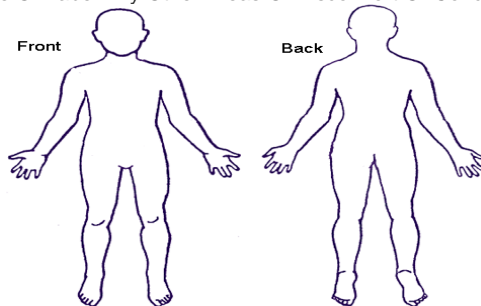
symptoms ↑ with activity                      symptoms ↓ with activity

Date of Injury: \_\_\_\_\_

If no injury, when did this problem begin? \_\_\_\_\_

- Have you been given a diagnosis for any of these conditions? If so, what? \_\_\_\_\_
- To what extent does the condition(s) interfere with your daily activity (work, exercise, sleep, intimacy, etc...)?  
 \_\_\_\_\_
- What kind of treatments have you tried for your problems? \_\_\_\_\_

Please Circle Or Label Any Other Areas Of Discomfort Or Concern



PLEASE RATE YOUR :	LOW/POOR                      (PLEASE CIRCLE A NUMBER)                      HIGH/GREAT									
	1	2	3	4	5	6	7	8	9	10
Exercise Level	1	2	3	4	5	6	7	8	9	10
Nutrition	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Stress Level	1	2	3	4	5	6	7	8	9	10
Overall Health	1	2	3	4	5	6	7	8	9	10

(Please Circle One Below)

I Feel **Older** than my actual age

I Feel **my age**

I feel **Younger** than my actual age

## HEALTH GOALS

If you **did not** have any of the previously listed health conditions, how would your life be better?

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**What are your health goals:** (please circle)

Get fit      Eat better      Reduce stress      Stop smoking      Reduce pain  
Increase my mobility      Improve my posture      Improve my sleep      Lose Weight  
Other: \_\_\_\_\_

## GOALS FOR MY CARE

Patients seek care in our wellness center for a variety of reasons. Some are looking for overall health and wellness, some are looking for correction of a condition and a few are looking for relief care. The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired at this time.

- I want the doctor to select the type of care that is appropriate for me.**
- Comprehensive Care** - Bring whatever is malfunctioning in my body to the highest state of health possible with chiropractic and wellness care.
- Corrective Care** – Correcting and relieving the cause of the problem as well as the symptoms.
- Relief Care** – Symptomatic relief of pain and discomfort only.

## HEALTH HABITS

Do you smoke?       Yes       No  
Do you drink alcohol?       Yes       No  
Do you drink coffee?       Yes       No  
Do you exercise regularly?       Yes       No  
Do you wear       Orthotics       Heel Lifts       Arch Supports

## MEDICATIONS I NOW TAKE

Nerve Pills (Neurontin, Naproxen, etcx...)  
 Pain Killers (Vicodin, Oxycontin, etc...)  
 OTC Meds (Ibuprofen, Aspirin, Tylenol, Advil)  
 Muscle Relaxers  
 Blood Pressure Medicine  
 Insulin  
 Stimulants  
 Blood Thinners  
 Tranquilizers  
 \_\_\_\_\_  
 \_\_\_\_\_

## HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

Severe or Frequent Headaches       Arthritis       Tuberculosis  
 Sinus Problems       Diabetes       Shingles  
 Dizziness       Cancer       Hepatitis  
 Frequent Neck Pain       Chemotherapy       HIV/AIDs  
 Loss of Sleep       Heart Murmur       Anemia  
 Pain Between the Shoulders       Asthma       STDs  
 Lower Back Problems       Thyroid Problems  
 Digestive Problems       Kidney Problems  
 Ulcers/Colitis       Difficulty Breathing  
 Alcohol/Drug Abuse       Rheumatic Fever  
 Heart Surgery/ Pacemaker       Congenital Heart Defect  
 Numbness or Pain In Arms/Legs/Hands

## FOR WOMEN ONLY

Are you pregnant?  
 Yes       No  
Are you nursing?  
 Yes       No  
Are you taking birth control?  
 Yes       No  
Do you experience painful periods?  
 Yes       No  
Do you have irregular cycles?  
 Yes       No  
Do you have breast implants?  
 Yes       No

## AUTHORIZATION FOR CARE AND POLICIES

I hereby authorize the practitioners of Gig Harbor Chiropractic and Massage to work with my condition through the use of adjustments, massage, or other physical therapy modalities to my affected areas, as he or she deems appropriate. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment.

**Chiropractic:** including but not limited to, spinal and extremity adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function, nutritional advice, home and wellness care, muscle and myofascial release.

**Massage:** including but not limited to, manual therapy to assist with relaxation, stress reduction, pain management, body awareness and integration of mind, body and spirit.

~Please understand that massage is booked hourly and your massage will end five to ten minutes prior to the next scheduled appointment. (This means that a one-hour massage is approximately 55 minutes and a half hour massage is approximately 25 minutes.) If you are running late, kindly take a moment to call and we will do our best to accommodate you. If you are more than 15 minutes late, your session will either be shortened or rescheduled.

~Please be advised that when a chiropractor of Gig Harbor Chiropractic and Massage refers you for massage you have the freedom to choose any licensed massage therapist to perform your treatment. The purpose of our office to have massage therapy is to expand our patients' choice of quality Therapists, not to direct you to any particular therapist unless required by your insurance carrier.

**Cancellation Policy:** Please be on time for your appointment as our hours are limited and we are often booked in advance. There is no-show charge for cancellations received at **least 24 hours in advance**. If you must cancel/reschedule with less than 24 hours notice or you do not show for an appointment, we reserve the right to charge **\$35.00** for the scheduled appointment. If the appointment is for a Monday, we must be notified by closing on the Friday prior to your Monday appointment. We will also be doing a courtesy reminder call prior to your massage appointment.

We reserve the right to refuse or discontinue service at any time, for any reason, in an effort to ensure the safety of our clients and ourselves. If possible we will provide a referral to another provider.

I hereby release Gig harbor Chiropractic and Massage from any and all liability, which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation. I have reported to the best of my knowledge all health conditions that I am aware of and will inform my practitioner of any changes to my health. The practitioner will not be held responsible for any health conditions or diagnosis' which are pre-existing, given by another health care practitioner, or are not related to the conditions diagnosed and/or treated at this clinic.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance right and benefits (if applicable) directly to the provider for services rendered. I hereby authorize my practitioner(s) of Gig Harbor Chiropractic and Massage permission to consult the patients' primary health care providers regarding my health and treatment.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Guardian or Spouse's  
Signature Authorizing Care \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Insurance Company Name \_\_\_\_\_

Group Number (Plan, Local, Policy #) \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

### About the Insured Person

Name \_\_\_\_\_

Insured Social Security # \_\_\_\_\_

Relation \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

You Do Not Need To Fill  
This Section Out, If You  
Have Given Our Office Staff  
Your Health Insurance Card  
And Identification.

