New Patient Registration

Please note that all information is strictly confidential.

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Here at this office we offer chiropractic and rehabilitative wellness care; this health information can be used for any and all of the above. 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. If you have any questions, please ask. Thank you.

First Name: _____ **Middle Initial:** _____

Last Name: _____

Date of Birth: ___/___/___ **Age:** _____ **Social Security #:** _____

Height: _____ **Weight:** _____

Gender: [ ] Male [ ] Female **Marital Status:** [ ] Married [ ] Single [ ] Life Partner

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

We offer a complementary monthly Wellness eNewsletter for our patients.
Email Address: _____

Occupation: _____ **Employer:** _____

In Case of Emergency Contact: _____ Relationship & Phone: _____

Financially Responsible Party: [ ] Self [ ] Other-Name, Address, Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

Insurance Information: If you haven't done so already, please *pre-verify* your benefits. We are not responsible for any misquote of said benefits. If we will be assisting you in billing your insurance, please fill out the following:

Name of Insurance Provider: _____

Name of Policy Holder (Primary Plan Holder): _____ DOB: _____

Policy Holder's Address & Phone Number: _____

Member ID Number: _____

Insurance Phone Number (back of card): _____

Patient/Guardian Signature: _____ Date: _____

SoundCare Chiropractic
4347 Roosevelt Way NE ● Seattle, WA 98105 ● Office: (206) 633-5556 ● Fax: (206) 633-5559

Health History Questionnaire

Reason #1 for contacting our office: _____

❒ mild ❒ ❒ moderate ❒ ❒ severe ~ Pain on a scale of 0-10 (0 being no pain) ___/10

❒ constant ❒ intermittent

❒ getting worse ❒ getting better ❒ no change

❒ symptoms ↑ with activity ❒ symptoms ↓ with activity

Date of Injury: _____

If no injury, when did the problem begin? _____

Reason #2 for contacting our office:_____

❒ mild ❒ ❒ moderate ❒ ❒ severe ~ Pain on a scale of 0-10 (0 being no pain) ___/10

❒ constant ❒ intermittent

❒ getting worse ❒ getting better ❒ no change

❒ symptoms ↑ with activity ❒ symptoms ↓ with activity

Date of Injury: _____

If no injury, when did the problem begin? _____

Reason #3 for contacting our office: _____

❒ mild ❒ ❒ moderate ❒ ❒ severe ~ Pain on a scale of 0-10 (0 being no pain) ___/10

❒ constant ❒ intermittent

❒ getting worse ❒ getting better ❒ no change

❒ symptoms ↑ with activity ❒ symptoms ↓ with activity

Date of Injury: _____

If no injury, when did the problem begin? _____

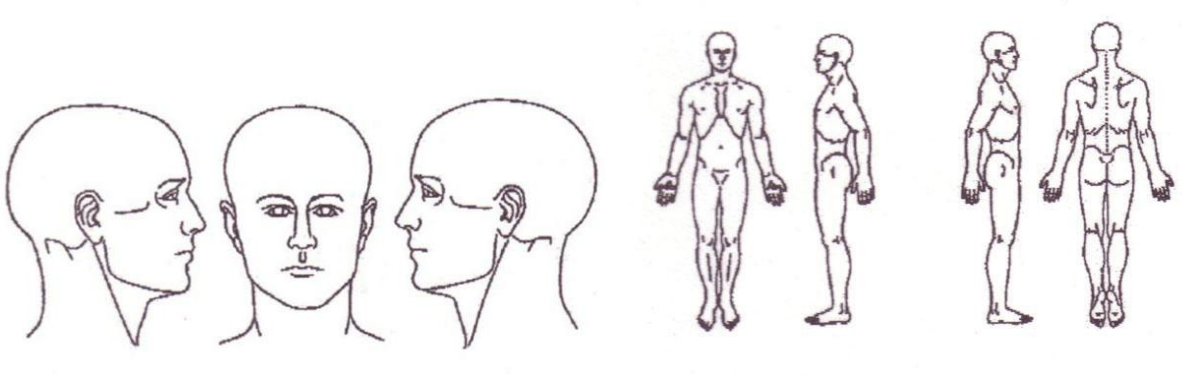
Have you been given a diagnosis for any of these conditions? If so, what?

_____

To what extent does the condition(s) interfere with your daily activity (work, exercise, sleep, sex etc.)?_____

What kind of treatments have you tried? _____

Please indicate any areas causing pain or distress:



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Past Medical History:
Please note dates of each:

❒Mental Illness	❒Diabetes	❒Hepatitis	❒HIV+	❒AIDS	❒Herpes
❒High Blood Pressure	❒Heart Disease	❒Asthma	❒Allergies	❒Stroke	❒Arthritis
❒Rheumatic Fever	❒Gall Stones	❒Venereal Disease	❒Osteoporosis	❒Seizures	❒Parasites
❒Mononucleosis	❒Chronic Fatigue	❒Thyroid Problems	❒Kidney Stones	❒Ulcers	❒Cancer

❒Other_____

Surgeries (types & dates): _____

_____

Significant Traumas: _____

Significant Dental Work:_____

Other: _____

Allergies (drugs, chemicals, foods, etc.): _____

Occupational Stress (chemical, physical, psychological): _____

Birth History (prolonged labor, forceps, premature, etc.): _____

Family Medical History:

❒Cancer ❒Heart Disease ❒Asthma ❒Diabetes ❒Stroke
❒Allergies ❒High Blood Pressure ❒Seizures ❒Other_____

Medications:

What medications and/or supplements are you currently taking?_____

_____

Have you had any courses of antibiotics recently? ❒Many ❒A few ❒1 or 2 ❒None

Habits:

Do you have a regular exercise program? Please describe: _____

Usage of:

Cigarette _____ per _____ Alcohol _____ per _____ Drugs _____ per _____
Tea _____ per _____ Coffee _____per _____ Soft Drinks _____ per _____

Check all that apply, and for each note if it is current or past.

General

❒Night Sweats	❒Recurrent Infections	❒Fatigue
❒Sweat easily	❒Bleed or bruise easily	❒Poor Sleep
❒Overweight	❒Poor Balance	❒Edema
❒Underweight	❒Sudden energy drops: Time of day _____	

Head/Eyes/Ears/Nose/Throat

❒Sore eyes	❒Facial Pain	❒Nasal discharge	❒Headaches Where _____ When _____	
❒Blocked nose	❒Nose bleeds	❒Discharge from ear	❒Migraines	❒Ringing in ears
❒Hoarseness	❒Snoring	❒Sores on lips/mouth	❒Poor hearing	❒Tonsillitis
❒Dizziness	❒Grinding teeth	❒Recurrent sore throat	❒Excessive Tearing	❒Blurry vision
❒Eye Pain	❒Color blindness	❒Night blindness	❒Swollen glands	❒Squint
❒Glasses	❒Teeth problems	❒Spots in front of eyes	❒Other _____	

Skin

❒Rashes ❒Itching ❒Eczema ❒Oozing ❒Pimples ❒Dry skin / scalp ❒Recent moles ❒Changes in hair/skin
❒Other _____

Genital-urinary

❒Pain on urination ❒ Prostate problems ❒Frequent urination ❒Blood in urine ❒Kidney stones
❒Decrease in urinary ❒Unable to hold urine ❒Incontinence at night ❒Dribbling urination
❒Changes in sexual drive ❒Rashes ❒Impotency ❒Other _____
❒Do you wake at night to urinate? How many times? _____

Cardiovascular

❒Pacemaker ❒High Blood Pressure ❒Low Blood Pressure ❒Chest discomfort/pain
❒Heart Palpitations ❒Cold hands or feet ❒Swelling of hands or feet ❒Blood Clots
❒Spider veins ❒Fainting ❒Other_____

Musculoskeletal

❒Neck ache/pain ❒Back ache/pain ❒Knee ache/pain ❒Shoulder pain ❒Elbow/Forearm pain
❒Hand/Wrist pain ❒Foot/Ankle pain ❒Joint/Bone problems ❒Torn tissues ❒Muscle pain/weakness
❒Hernia ❒Prosthesis ❒Other_____

Neurological

❒Seizures ❒Nerve damage ❒Paralysis ❒Difficulty in concentrating ❒Sleep disorder
❒Stroke ❒Concussion ❒Vertigo ❒Lack of coordination ❒Poor memory
❒Loss of balance ❒Other _____

Gynecological

of pregnancies_____ # of births _____
Age of 1st menses_____ Age of menopause_____
Are you pregnant now? ❒yes ❒no Due Date: _____
Are you breast feeding? ❒yes ❒no
❒PMS ❒Irregular periods ❒Painful periods ❒Fibroids ❒Endometriosis

Digestion

❒Bad breath ❒Change in appetite ❒Loose stools / Diarrhea ❒Heartburn ❒Indigestion
❒Weight gain ❒Weight loss ❒Bloody stools ❒Nausea ❒Pale stools
❒Abdominal pain or cramps ❒Black stools ❒Hemorrhoids ❒Vomiting
❒Pain with passing stools ❒Gas ❒Rectal pain ❒Bulimia
❒Anorexia nervosa ❒Constipation (not daily, or difficult)
❒Other _____

Respiratory

❒Difficulty breathing ❒Pain with breathing ❒Shallow breathing ❒Shortness of breath ❒Production of phlegm
❒Pneumonia ❒Asthma/Wheezing ❒Status asthmaticus
❒Recurrent cough ❒Bronchitis ❒Other _____

Behavioral

❒Easily susceptible to stress ❒Panic Attacks ❒Anxiety ❒Fear ❒Depression ❒Substance abuse
Have you ever been treated for emotional problems? ❒yes ❒no
What type and for how long? _____

Comments: _____

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Patient/Guardian Signature: _____ **Date:** _____

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