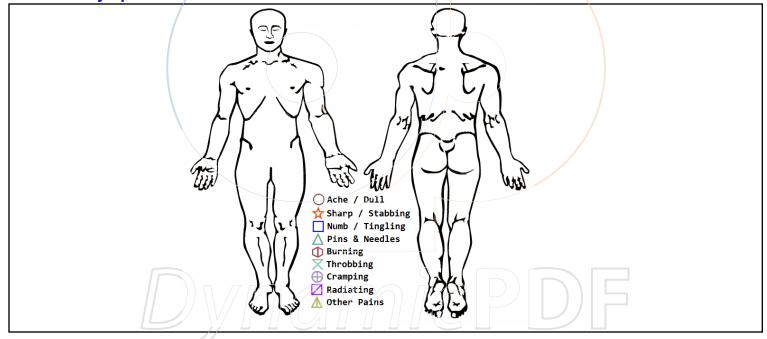


Health First Chiropractic 1519 9th Street Suite 101 Marysville, WA 98270 360.658.1987

Patient Information:

Date			SSN	Birthday
First Name			Middle Name	Last Name
Sex	Male	Female	Height	Weight
Married/Civil Union:			Spouse Name	# of Children
Home #			Cell #	Work #
Address				
City			State	Zip
Emergency Contact			Emergency Relation	Emergency Phone
Email				

Patient Symptoms:



Patient Social

Alcohol:	Daily	Weekly	Occasionaly	Never	Caffeine:	Daily	Weekly	Occasionaly	Never
Diet Food Products:	Daily	Weekly	Occasionaly	Never	Drugs:	Daily	Weekly	Occasionaly	Never
OTC Stimulants:	Daily	Weekly	Occasionaly	Never	Exercise:	Daily	Weekly	Occasionaly	Never
Homemade Food:	Daily	Weekly	Occasionaly	Never	Processed:	Daily	Weekly	Occasionaly	Never
Soft Drinks:	Daily	Weekly	Occasionaly	Never	Tobacco:	Daily	Weekly	Occasionaly	Never
Water:	Daily	Weekly	Occasionaly	Never					

Chiropractic Experience:

Who referred you to our office:

Where did you hear about us? Newspaper Sign Yellow Pages Mailing Community Event

Have you been adjusted by a chiropractor before? Yes No If yes, Why?

Doctor's Name: Approximate Date of Visit

Other

Has any member of your family ever seen a wellness chiropractor? Yes No

Employer Information:

Employed: Employer Name

Employer Address:

Employer City: Employer State: Employer Zip:

Occupation: Work Supervisor: Supervisor #:

Work Duties:

Reason for this Visit:

Describe the reason for this visit?

Please briefly describe, including the impact it has had on your life. Fall Job Chronic Discomfort Other Wellness Sports Auto Home Injury Briefly Explain: When did this concern begin? Has this concern: Gotten Worse Stayed Constant Come and Gone Work Does this concern interfere with: Sleep Daily Routine Other Activities Briefly Explain: Has this concern occurred before? Yes No Briefly Explain: Have you seen other doctor's for this concern? Yes No Doctor's name: Type of Treatment: Results: Good Bad Indifferent

Personal Health History

Last Physical Exam: Primary Phys: Phys Phone #: Phys City: Phys State: Phys Zip: Health Conditions: Previous Chiro Care: Condition(s) treated: Yes No Date: Chance Pregnant: Yes No Planning: Yes No Medications: Supplements:

Personal Incident History:

Broken Bones:	Yes	No	Treatment:	Yes	No	Explain
Sprains/Strains:	Yes	No	Treatment:	Yes	No	Explain
Hospitalized:	Yes	No	Explain:			
Surgery:	Yes	No	Explain:			
Auto Accident:	Yes	No	Treatment:	Yes	No	Explain
Struck Unconscious:	Yes	No	Treatment:	Yes	No	Explain
Eating Disorder:	Yes	No	Explain:			
Stroke:	Yes	No	Explain:			



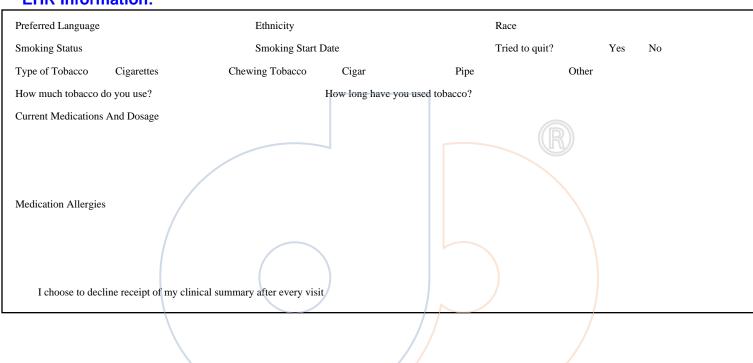
Health Checklist:

Ticaltii Officeriist.								
Alcoholism	Allergies	Anemia						
Arteriosclerosis	Arthritis	Asthma						
Autoimmune Disease	Back Pain	Bleeding Disorders						
Breast Lump	Bronchitis	Bruise Easily						
Cancer	Cataracts	Chest Pain						
CHF	Cold Extremities	Constipation						
COPD/emphysema	Cramps	CVA (stroke/TIA)						
Dementia/Alzheimer's	Depression	Diabetes						
Diagnosed emotional/mental	Digestion Problems	Dizziness						
Epilepsy	Excessive Menstruation	Eye Pain or Difficulties						
Fatigue	Frequent Urination	Gallbladder disease/stones						
Glaucoma	Gout	Headache						
Hemorrhoids	High Blood Pressure	Hot Flashes						
Irregular Heart Beat	Irregular Menstrual Cycle	Kidney Infection						
Kidney Stones	Liver disease/cirrhosis	Loss of Balance						
Loss of Memory	Loss of Smell	Loss of Taste						
Lung disease	Macular Degeneration	Migraines						
Nosebleeds	Pacemaker	Parkinson's						
Polio	Poor Posture	Prostate Trouble						
Retinal Disease	Sciatica	Seizures						
Shortness of Breath	Sinus Infection	Skin Sensitivity						
Sleep Problems/Insomnia	Smoked	Spinal Curvatures						
Stroke	Swelling of Ankles	Swollen Joints						
Thyroid Condition	Tuberculosis	Ulcers						
Varicose Veins	Venereal Di <mark>s</mark> ease	Other						
Have you had any of these Cardiovascular Diseases? Please select all that apply. Myocardial infarction Hypercholesterolemia								
Bypass surgery	Coronary artery disease							
Do you have Diabetes? If so what type?								
Type I Type II Juvenile								
Do you have any stomach/digestive issues? Please select all that apply.								
Ulcers	Reflux	IBS						

Family Health History:

Family Health History

EHR Information:





Signature Date: