Dr. David Cox **2401 15th Street** **Anacortes, WA 98221** **360-299-4500**

PATIENT INFORMATION

Name:_____
Addess:_____
City:_____ State:_____ Zip:_____

Phone: C-_____ H-_____ W-_____
Cell phone carrier_____ for appointment text reminders

Sex: F____ M____ Date of birth:_____
Divorced_____ Married_____ Separated_____ Single____ Widow(er)_____
Occupation:_____
E-Mail:_____

INSURANCE INFORMATION

Insurance Company:_____
Subscriber: _____ Date of birth:_____
Relationship to patient: guardian / parent_____ self_____ spouse_____ other_____
Subscriber Employer:_____

Whom may we thank for referring you:_____

Is your condition due to an accident: NO _____ YES_____
If so, what type Vehicle _____ Work-related_____ Other _____ Date of Injury_____

ASSIGNMENT & RELEASE

I certify that I have insurance coverage and assign directly to Sound Health Chiropractic, LLC 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 this signature on all insurance submissions.

I authorize Sound Health Chiropractic to release any information, including the diagnosis and the records, of any treatment or examination rendered to me or my dependent for the periods of such chiropractic care to third party payers and/or health practitioners.

_____ _____
Signature Date

Dr. David Cox **Sound Health Chiropractic** **360/299-4500**
2401 15th Street, Anacortes, WA 98221

@HEALTH REPORT

NAME: _____ DOB: _____ DATE: _____

Reason for seeking care: _____

List any other doctors/therapists seen for this: _____

List any diagnosis and type of treatment: _____

Have you had similar accidents or injuries before? __ Yes __ No If yes, explain: _____

Have you received chiropractic treatment previously? __ Yes __ No

If yes, explain: _____

Have you been treated for any health condition by a physician in the last year? __ Yes __ No

If yes, explain: _____

Are you currently taking medication? __ Yes __ No List medications: _____

_____

Have you taken medication in the past? __ Yes __ No List medications: _____

List conditions you are taking medications for: _____

List the approximate dates of any surgery or treated conditions:_____

_____

Family History: Health conditions, age of death and cause of death.

Father: _____

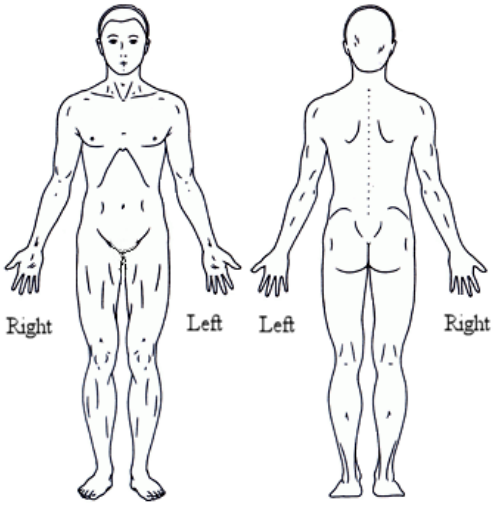
Mother: _____

Brother/s & Sister/s: _____

Do you smoke Y/N ____ • Alcohol Y/N __Daily __Weekly __Social Occasions • Caffeinated drinks per day ____

Do you take Vitamins/Supplements Y/N If yes, type and how often _____

Please circle degree of pain, 0 = none, 10 = severe: 0 1 2 3 4 5 6 7 8 9 10Using the symbols below, mark on the pictures where you feel:



Numbness = = = Sharp/Stabbing / / /
Dull Ache OOO Pins and Needles + + +
Burning XXX Other _____ ^ ^ ^

What activities aggravate your condition/pain?_____

What activities lessen your condition/pain?_____

Is this condition worse during certain times of the day? Y / N

Is this condition interfering with Work?_____ Sleep?_____

Routine?_____Other?_____

Is this condition progressively getting worse?_____

Do you experience pain with: Standing • Walking • Sitting • Bending • Lying down • Lifting • Sports • Other _____

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**Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy
_____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____