

Patient \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email: \_\_\_\_\_

Address \_\_\_\_\_

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

Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Single  Married Referred by: \_\_\_\_\_

Are you interested in On-Line Bill Pay  Yes  No (if interested please inquire at front desk)

Preferred Method of Contact for reminder calls:  Email  Text  Voice Call w/recorded message

Is this related to Auto Accident or Workers Comp Claim:  Yes  No If yes Claim #: \_\_\_\_\_

**EMPLOYER**

Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_

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

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

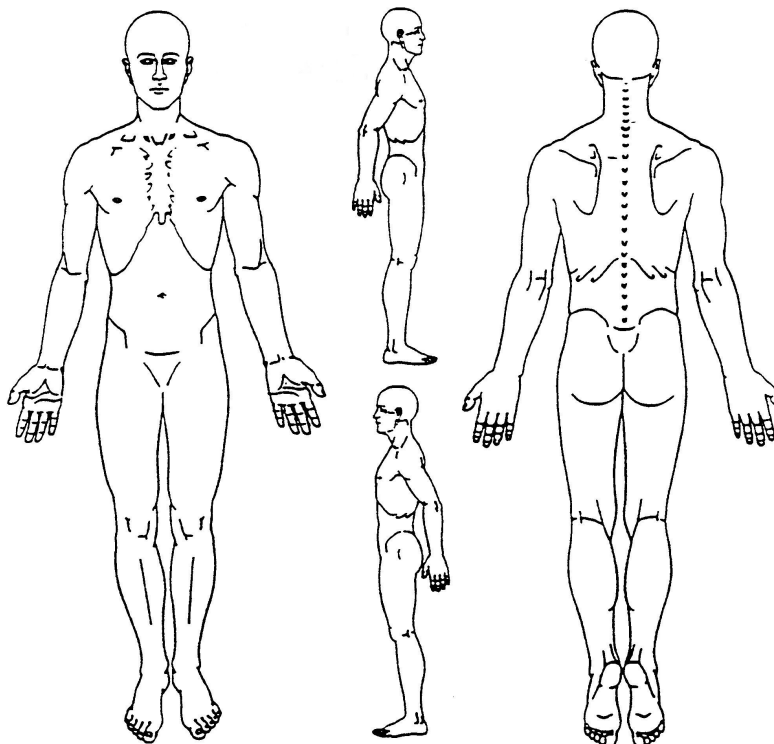
**Please mark areas of pain:**

Using the scale below, please rate your level of pain today from zero (no pain) to ten (worst possible pain):

1 2 3 4 5 6 7 8 9 10

Using the body chart below, indicate the region(s) of your complaint using the following symbols:

- A - Aching**
- B - Burning**
- N - Numbness/tingling**
- S - Stabbing/sharp**
- T - Tightness**
- O - Other**



**Camas Family Health Center**  
 235 NE 6th Avenue Camas, WA 98607  
 Phone: 360-834-5126 Fax: 360-838-1582

Patient's Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe
Do you wear: <input type="checkbox"/> heel lifts <input type="checkbox"/> sole lifts <input type="checkbox"/> shoe inserts <input type="checkbox"/> orthotics
What is the age of your mattress? _____ Is it... <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable?
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)

**Have you ever:**

Yes / No; if yes please briefly explain and state what year:

- Had a broken bone: \_\_\_\_\_
- Had strains or sprains: \_\_\_\_\_
- Had surgery performed: \_\_\_\_\_
- Been struck unconscious: \_\_\_\_\_
- Had X-rays/ other imaging performed: \_\_\_\_\_

Do you:

Yes / No; if yes please briefly explain:

- Take minerals, herbs or vitamins: \_\_\_\_\_
- Have allergies: \_\_\_\_\_
- Take prescription medications: \_\_\_\_\_

<b>Habits</b>	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

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**FAMILY HEALTH HISTORY:** Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture. (ie: cancer, high blood pressure, diabetes, high cholesterol)

Relationship	Present and Past Health Problems

## PERSONAL HEALTH HISTORY

**Patient's Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Date** \_\_\_\_\_

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond appropriately, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

**O=Occasional      F=Frequent      C=Constant**

<p><b>O F C</b></p> <p><b>Muscle / Joint</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><b>General</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p><b>Genitourinary</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p>	<p><b>O F C</b></p> <p><b>Eye, Ear, Nose and Throat</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p><b>O F C</b></p> <p><b>Skin</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><b>Pain or numbness in</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><b>Respiratory</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><b>Women only</b></p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p>	<p><i>Check any of the following conditions you currently have or have had:</i></p> <p><b>Past/Present</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> <input type="checkbox"/> Cholera</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold sores</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Diphtheria</p> <p><input type="checkbox"/> <input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> <input type="checkbox"/> Edema</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever blisters</p> <p><input type="checkbox"/> <input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> <input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> <input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> <input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Measles</p> <p><input type="checkbox"/> <input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Pleurisy</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Typhoid fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Whooping cough</p>
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Are you pregnant? "Yes  "No

If yes, how many months? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Describe what brings you in today: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is it getting worse?  Yes  No

Does it bother your Work Sleep Other (please specify) \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

Have you seen a chiropractor before?  Yes  No If yes, how long ago? \_\_\_\_\_

For what reason? \_\_\_\_\_

Are you under the care of a physician?  Yes  No If yes, for what reason? \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Where \_\_\_\_\_

**Primary Insurance (if applicable) Name:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

Primary Insurance ID number: \_\_\_\_\_ Group number: \_\_\_\_\_

Name of Primary Insurance Holder: \_\_\_\_\_ Date of Birth Primary Ins. Holder: \_\_\_\_\_

**Secondary Insurance (if applicable) Name:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

Secondary Insurance ID number: \_\_\_\_\_ Group number: \_\_\_\_\_

Name of Primary Insurance Holder: \_\_\_\_\_ Date of Birth Primary Ins. Holder: \_\_\_\_\_

**PATIENT AGREEMENT - ASSIGNMENT AND RELEASE**

I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly all medical benefits otherwise payable for services. I understand that I am financially responsible for all charges whether or not paid by insurance, and I have read and understand the financial policy of this office. I authorize the use of this signature on all my insurance submissions and to obtain other medical records and radiographic/CT/MRI images and there corresponding reports.

Signature of Insured/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**FINANCIAL POLICY**

Payment for copayment and supplements is due at the time rendered. ***Payment on the day of service is eligible for a time sensitive discount if you do not have insurance coverage.*** You will be notified of co-insurance or other balances within 30 days of our receiving your Estimate of Benefits from your insurance company. There is a \$40 fee for NSF checks. Accounts over 60 days past due will incur a \$25 fee, unless payment arrangements were made. If you need assistance or need to make special arrangements, please talk to the staff. A no show fee of \$30 will be charged if a 24 hour notice of cancelation was not received.

**CONSENT TO TREAT**

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat application, manual traction, therapeutic exercise and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurologic impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per million adjustments for adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I have read the copy of Camas Family Health Centers Patient Privacy Policy.

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_