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

Patient _____
Last Name First Name Middle Initial

Home Phone _____Cell Phone_____ email: _____

Address_____

City/State/Zip_____

Birth Date_____ Age____ ☐ Single ☐ Married ☐ Widowed ☐ Separated Divorced

Condition Related to: ☐ Auto Accident ☐ Work-related Injury ☐ Other Injury Illness Unknown

EMPLOYER

Company Name_____ Phone_____

Occupation_____

Address_____ City _____ State___ Zip_____

Emergency Contact

Name_____ Relationship_____

Phone_____

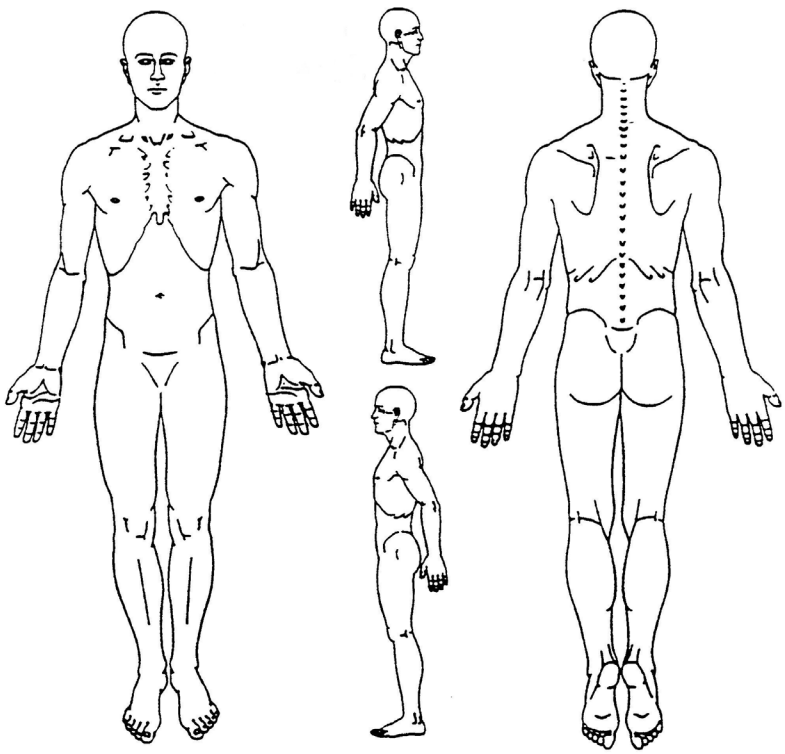
Please mark areas of pain:

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? ☐ Yes ☐ No If yes, please describe
Have you had any mental or emotional disorders? ☐ Yes ☐ No Please describe
Do you wear: ☐ heel lifts ☐ sole lifts ☐ shoe inserts ☐ orthotics
What is the age of your mattress? Is it... ☐ comfortable? ☐ uncomfortable?
How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ 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 any allergies: _____

☐ ☐ Take prescription medications: _____

_____

Habits	None	Light	Mod	Heavy
Alcohal	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

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

_____

_____

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, hight cholosterol)

Relationship	Present and Past Health Problems

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

PERSONAL HEALTH HISTORY

Patient's Name _____ **Birthdate** _____**Date**_____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benifit 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=Ocassional F=Frequent C=Constant

O F C
Muscle / Joint
- ☐☐☐ Arthritis
- ☐☐☐ Bursitis
- ☐☐☐ Foot trouble
- ☐☐☐ Hernia
- ☐☐☐ Low back pain
- ☐☐☐ Neck pain, stiffness
- ☐☐☐ Pain between shoulders
- ☐☐☐ Sciatica
- ☐☐☐ Spinal Curvature
- ☐☐☐ Swollen joints

General
- ☐☐☐ Allergy
- ☐☐☐ Chills
- ☐☐☐ Convulsions
- ☐☐☐ Dizziness
- ☐☐☐ Fainting
- ☐☐☐ Fatigue
- ☐☐☐ Fever
- ☐☐☐ Headache
- ☐☐☐ Loss of sleep
- ☐☐☐ Loss of weight
- ☐☐☐ Nervousness, depression
- ☐☐☐ Neuralgia
- ☐☐☐ Numbness
- ☐☐☐ Sweats
- ☐☐☐ Tremors

Cardiovascular
- ☐☐☐ Hardening of arteries
- ☐☐☐ High blood pressure
- ☐☐☐ Low blood pressure
- ☐☐☐ Pain over heart
- ☐☐☐ Poor circulation
- ☐☐☐ Rapid heartbeat
- ☐☐☐ Slow heartbeat
- ☐☐☐ Swelling of ankles

Genitourinary
- ☐☐☐ Bed-wetting
- ☐☐☐ Blood in urine
- ☐☐☐ Frequent urination
- ☐☐☐ Kidney infection
- ☐☐☐ Painful urination
- ☐☐☐ Prostate trouble

O F C
Eye, Ear, Nose and Throat
- ☐☐☐ Asthma
- ☐☐☐ Colds
- ☐☐☐ Crossed eyes
- ☐☐☐ Deafness
- ☐☐☐ Earache
- ☐☐☐ Ear discharge
- ☐☐☐ Ear noise
- ☐☐☐ Enlarged glands
- ☐☐☐ Enlarged thyroid
- ☐☐☐ Eye pain
- ☐☐☐ Failing vision
- ☐☐☐ Hay fever
- ☐☐☐ Hoarseness
- ☐☐☐ Nasal obstruction
- ☐☐☐ Near sightedness
- ☐☐☐ Nose bleeds
- ☐☐☐ Sinus infection
- ☐☐☐ Sore throat
  Tonsillitis

Gastrointestinal
- ☐☐☐ Colitis
- ☐☐☐ Colon trouble
- ☐☐☐ Constipation
- ☐☐☐ Diarrhea
- ☐☐☐ Difficult digestion
- ☐☐☐ Bloated abdomen
- ☐☐☐ Gallbladder trouble
- ☐☐☐ Hemorrhoids
- ☐☐☐ Jaundice
- ☐☐☐ Liver trouble
- ☐☐☐ Nausea
- ☐☐☐ Pain over stomach
- ☐☐☐ Poor appetite
- ☐☐☐ Vomiting
- ☐☐☐ Vomiting of blood

O F C
Skin
- ☐☐☐ Boils
- ☐☐☐ Bruise easily
- ☐☐☐ Dryness
- ☐☐☐ Hives or allergy
- ☐☐☐ Itching
- ☐☐☐ Skin eruptions (rash)
- ☐☐☐ Varicose veins

Pain or numbness in
- ☐☐☐ Shoulders
- ☐☐☐ Arms
- ☐☐☐ Elbows
- ☐☐☐ Hand
- ☐☐☐ Hips
- ☐☐☐ Legs
- ☐☐☐ Knees
- ☐☐☐ Feet

Respiratory
- ☐☐☐ Chest pain
- ☐☐☐ Chronic cough
- ☐☐☐ Difficult breathing
- ☐☐☐ Spitting up blood
- ☐☐☐ Spitting up phlegm
- ☐☐☐ Wheezing

Women only
- ☐☐☐ Congested breasts
- ☐☐☐ Cramps or backache
- ☐☐☐ Excess menstrual flow
- ☐☐☐ Hot flashes
- ☐☐☐ Irregular cycle
- ☐☐☐ Lumps in breast
- ☐☐☐ Menopause
- ☐☐☐ Painful menstruation

Are you pregnant? ¨Yes ¨No

If yes, how many months?_____

How many children do you have?
_____

Check any of the following conditions you currently have or have had:

Past/Present
- ☐ ☐ Alcoholism
- ☐ ☐ Anemia
- ☐ ☐ Appendicitis
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Cancer
- ☐ ☐ Chicken pox
- ☐ ☐ Cholera
- ☐ ☐ Cold sores
- ☐ ☐ Diabetes
- ☐ ☐ Diptheria
- ☐ ☐ Eczema
- ☐ ☐ Edema
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy
- ☐ ☐ Fever blisters
- ☐ ☐ Goiter
- ☐ ☐ Gout
- ☐ ☐ Heart disease
- ☐ ☐ Herpes
- ☐ ☐ Influenza
- ☐ ☐ Lumbago
- ☐ ☐ Malaria
- ☐ ☐ Measles
- ☐ ☐ Miscarriage
- ☐ ☐ Multiple sclerosis
- ☐ ☐ Mumps
- ☐ ☐ Pacemaker
- ☐ ☐ Pleurisy
- ☐ ☐ Pneumonia
- ☐ ☐ Polio
- ☐ ☐ Rheumatic fever
- ☐ ☐ Scarlet fever
- ☐ ☐ Stroke
- ☐ ☐ Tuberculosis
- ☐ ☐ Typhoid fever
- ☐ ☐ Ulcers
- ☐ ☐ Venereal disease
- ☐ ☐ Whooping cough

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_____

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

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 is requested for all office services at the time rendered and may be paid by cash, debit/credit card, or check. ***Payment on the day of service is eligible for a time sensitive discount.*** If you have insurance that pays for chiropractic, we may be able to bill for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements, please talk to the staff.

CONSENT TO TREAT

To Camas Family Health Center Patients:

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 Famly Health Centers patient privacy policy.

Patient signature: _____ Date: _____

*If you would like a copy of CFHCs patient privacy policy, please advise the front desk.