HALEY CHIROPRACTIC CLINIC

1919 NO. PEARL ST. #A4

TACOMA, WA 98406

CONFIDENTIAL PATIENT HISTORY **DATE**_____

Name_____Phone_____Cell #_____

Address_____City_____State _____ Zip_____

SS#_____ Date of Birth _____ Marital Status: S M W D

Employer_____Address_____

_____Work Phone _____Ext._____

Email Address: _____

Have you received chiropractic care in the past? ☐ Yes ☐ No

Are you currently under chiropractic care? ☐ Yes ☐ No

The reason for this visit: ☐ PI (automobile accident) ☐ L&I (injury on the job) ☐ Other_____

How did you hear about our office? ☐ Website ☐ Phonebook ☐ Other _____

INSURANCE COVERAGE

We can bill your insurance as a courtesy to you. Will we be billing insurance for you? ☐ **Yes** ☐ **No**

☐ Private Insurance ☐ Medicare Coverage (also provide your supplemental insurance info)

Name of Insurance_____Address_____

Phone_____Policy Number_____Group #_____

Policy Holders Name_____Employer_____

SS# of policy holder_____ Date of birth _____

HEALTH INFORMATION

Chief Complaint:_____

List all symptoms: _____

When and how did this start: _____

Have you ever had similar symptoms? If yes, when ? _____

☐ Is it getting better? ☐ Worse? ☐ Unchanged?

List any other Doctors or Therapists you have seen for this condition:

1._____ 3. _____

2._____ 4. _____

What were you told _____

_____

What type of treatment did you receive _____

Remarks:_____

_____

List previous accidents or injuries (auto, work, falls, etc.)

1. _____ 3. _____

2. _____ 4. _____

List and previous surgeries and year_____

List any previous illnesses: _____

List medication you are currently taking or have taken in the last six months: _____

_____

List any self-medications, i.e. vitamins, minerals, herbs, remedies, etc. : _____

_____

Do you smoke?_____ . If yes, how many packs per day? _____.

Use alcohol? _____. If yes, list oz. per day _____

Use of laxatives, aspirin or other preparations constantly? □ Yes □ No

If yes, please give dosage amount of each

_____

_____.

FAMILY MEDICAL HISTORY: (i.e. parents, siblings)

_____

Is there anything else that is causing you considerable concern, worry or stress?_____

_____.

SYSTEMS REVIEW

In the section below list any problem you now have, or have had. (For example: Head conditions might include headache, migraines, fainting, dizziness, etc) If there is a problem that you are aware of please list it. If no problem exists please **N/A** after that system.

Head_____

Ear, eyes, nose, throat: _____

Lungs/respiratory: _____

Heart/circulation

_____

Stomach/intestine/colon: _____

Kidney/bladder/urinary: _____

Liver/gallbladder/pancreas/spleen: _____

Skin/hair/nails: _____

Hematological/bleeding/anemia: _____

Bone or muscle other than already described: _____

Nerve or nervous involvement other than already described: _____

Endocrine system, i.e., thyroid, adrenal, pituitary, etc. : _____

Central nervous system, i.e., stroke, epilepsy, etc. : _____

Lymph glands, i.e., swelling, painful, etc. : _____

Allergies: _____

HALEY CHIROPRACTIC CLINIC

NAME: _____

DATE:_____

1. **BRIEFLY DESCRIBE YOUR JOB DUTIES**:

_____

_____

_____

2. **CIRCLE ALL THAT APPLIES TO YOUR JOB DUTIES**:

SITTING / STANDING / DESK / COUNTER / WORK BENCH

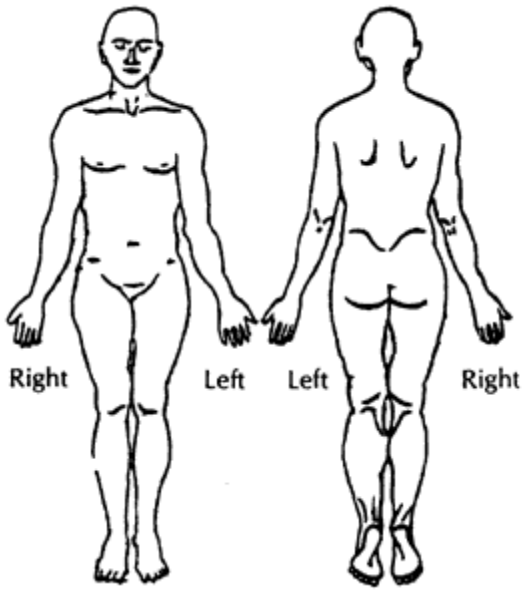
LIFTING / BENDING / STOOPING / TWISTING / CARRYING / WALKING

ARMS OVERHEAD / OTHER:_____

3. **PHYSICAL WORK STRAINS**: LIGHT MODERATE HEAVY STRENUOUS

4. **LIST EXERCISE/SPORTS**: _____

NOTE THE SYMPTOMS YOU ARE EXPERIENCING ON THE DRAWING BELOW:



HEIGHT:_____

WEIGHT:_____

Haley Chiropractic Clinic
1919 N Pearl St., # A-4
Tacoma, WA 98406

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease,Cancer,Diabetes		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____