

Date \_\_\_\_\_

## Personal History Form

The following is a confidential questionnaire, which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

Name \_\_\_\_\_ S.S.# \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Gender: Male / Female Marital Status \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employment address \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_ Have you ever been treated by a Chiropractor before? Yes / No

### Insurance Information

Primary Insurance Company & Plan Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber DOB and SS #: \_\_\_\_\_

Relationship to subscriber: \_\_\_\_\_ Is your plan a; (circle) POS PPO EPO HMO

Secondary Insurance Company & Plan Name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber DOB and SS #: \_\_\_\_\_

Relationship to subscriber: \_\_\_\_\_ Is your plan a; (circle) POS PPO EPO HMO

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What is your primary complaint? (Why are you seeking Chiropractic care)? \_\_\_\_\_

\_\_\_\_\_

How and when did the injury occur? \_\_\_\_\_

\_\_\_\_\_

Any additional complaints you would like to have treated? \_\_\_\_\_

\_\_\_\_\_

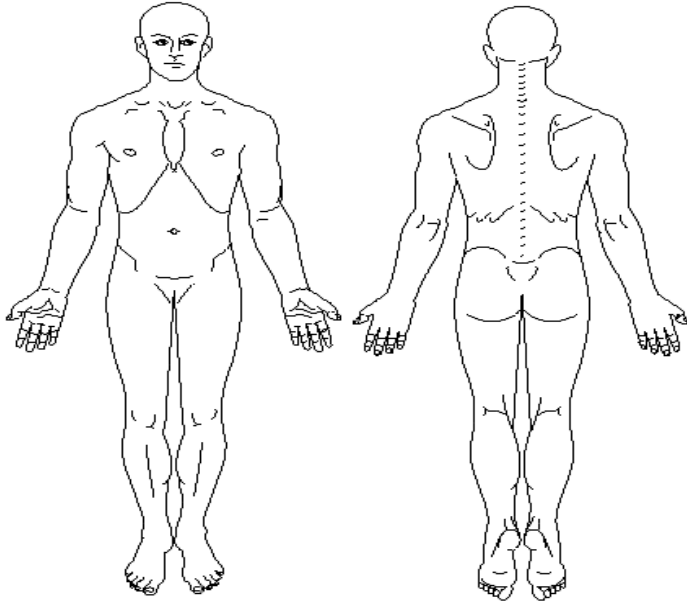
Is your pain the result of a motor vehicle accident? (*Additional Forms Required*) \_\_\_\_\_

If so, have you filed a legal suit? \_\_\_\_\_

Is your pain the result of a work-related injury? (*Additional Forms Required*) \_\_\_\_\_

If so, have you filed a worker's compensation claim? \_\_\_\_\_

Please shade in all areas of pain and discomfort and label the type of pain associated with the shaded areas. (I.E. Sharp, dull, ache, burning, stabbing, electrical, pins and needles, numbness, tingling, etc.)



Please indicate the type of symptoms associated with your complaint. (Circle all that apply)

- NUMBNESS
- TINGLING
- WEAKNESS
- DIZZINESS
- FAINTING
- PAIN AT NIGHT
- RADIATING PAIN
- CHANGES IN VISION
- CHEST PAIN OR PRESSURE
- UNEXPLAINED WEIGHT LOSS
- BOWEL OR BLADDER ISSUES

Please describe activities that you perform on regular basis that are now difficult to perform due to your pain/discomfort. This could be occupational, household, or leisurely activities:

Please list **accidents, injuries, illnesses, surgeries, and hospitalizations** you have had from childhood to now.

\_\_\_\_\_ Date or Age \_\_\_\_\_

\_\_\_\_\_ Date or Age \_\_\_\_\_

\_\_\_\_\_ Date or Age \_\_\_\_\_

\_\_\_\_\_ Date or Age \_\_\_\_\_

Please list any allergies that you have:

\_\_\_\_\_

\_\_\_\_\_

Central Washington Chiropractic Inc.

Fed. ID 20-8082891

Do you or other family members have a history of any of the following conditions?

Disease	Self	Specific Family Member
Arthritis	Self	Family member _____
Asthma	Self	Family member _____
Cancer	Self	Family member _____
Diabetes	Self	Family member _____
Heart Disease	Self	Family member _____
Hypertension	Self	Family member _____
Kidney Disease	Self	Family member _____
Depression	Self	Family member _____
Mental Illness	Self	Family member _____

Do you use tobacco? \_\_\_\_\_ If so, how much per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If so, how often? \_\_\_\_\_

What Medications, Vitamins, Supplements, Herbs do you take? (If you have a medication list we can take a copy)

Name	Reason
_____	_____
_____	_____
_____	_____
_____	_____

**Family Physician/Specialist Information**

If you are currently under the care of your Family Physician or a Specialist such as a Neurologist or Surgeon, please complete the information below. This allows us to communicate directly with these doctors and use a team approach to treat your condition most effectively.

Name of Family Physician/Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Office location: \_\_\_\_\_

Name of any Specialists consulted for your condition  
(Ex: Neurologist/Orthopedic Surgeon): \_\_\_\_\_ Phone: \_\_\_\_\_  
Office location: \_\_\_\_\_

**You have my permission to send these doctors information regarding my diagnosis, treatment, and progress.**

Initial and date: \_\_\_\_\_

**You have my permission to obtain records from these doctors related to the conditions I will be treated for at this office.**

Initial and date: \_\_\_\_\_

**I attest that the information above is true and accurate to the best of my knowledge:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_