PATIENT REGISTRATION **Bothell Chiropractic Clinic**

Name: ____ Home Phone: __________________________

Email: ____ Cell Phone: ____________________________

Address: ____ City: ______________ State: _______ Zip Code: ______________

Sex: _________ Social Security number: ___________________________________ Date of Birth: _____________________

Occupation: ____ Work Phone: ____________________________

Emergency Contact: ______________________________ Relationship: ________________ Phone: _____________________

Primary Care Physician: ____ Location: ___________________________________

Insurance Company: _____________________________ ID #: ____________________________ Group #: ________________

Subscriber's Name: ____ Date of Birth: ______________________

Secondary Insurance: _____________________________ ID #: ____________________________ Group #:________________

Subscriber's Name: ____ Date of Birth: ______________________

Describe complaint and symptoms: ____

____

When did you first notice this: ________________________ Has this happened before: ______________________________

How did it happen: ____

____

Any family history of this condition: ____

____

Other doctors seen for this condition: ____

Is this condition due to: Auto accident Y N On the job injury Y N

Please list any other health problems: ____

____

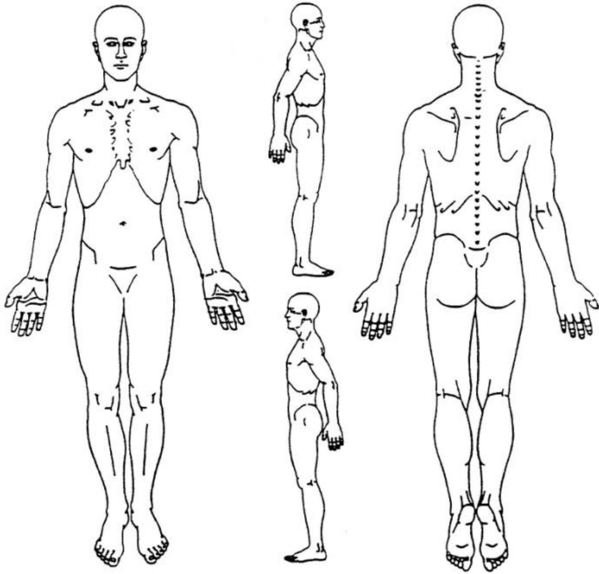
____

What is your pain level from 1-10 (10 being worse): ____

Type of pain: [ ] Sharp [ ] Aching [ ] Dull [ ] Shooting
[ ] Throbbing [ ] Burning [ ] Stabbing [ ] Electric

Over – Please complete both sides of form

Mark on the picture where you have pain



Rate intensity of pain:

[ ] Minimal: The symptoms are annoying, but no appreciable interference with daily activities.
[ ] Slight: the symptoms cause some interference in carrying out daily activities.
[ ] Moderate: The symptoms seriously cause interference in carrying out daily activities.
[ ] Marked: The symptoms prevent you from carrying out daily activities.

What increases the pain: ________________________________

____

____

What gives relief to the pain: ____

____

Have you had chiropractic care before: Y N Where: ____

Please list any surgeries you have had: ____

____

What medications are you currently taking: ____

____

____

Do you have any difficulty with the following:

[ ] Arm/ shoulder pain	[ ] Numbness of legs/feet	[ ] Neck pain
[ ] Back Pain	[ ] Numbness of arms/hands	[ ] Neck stiffness
[ ] Back stiffness	[ ] Headaches	[ ] Shortness of breath
[ ] Chest pain	[ ] Irritability	[ ] Sleep difficulty
[ ] Dizziness	[ ] Light headedness	[ ] Stomach upset
[ ] Pins-needles in arms/legs	[ ] Leg pain	[ ] Memory loss
[ ] Blurred vision	[ ] Fatigue	[ ] Nausea

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I hereby authorize the doctors, therapists, and whomever they designate as assistants to administer treatment as they deem necessary. I authorize the provider and /or managed care organization to release my information required to process insurance claims. I also authorize direct payment to Bothell Chiropractic Clinic for services rendered. I understand that, except as dictated by contractual limits, I am personally responsible for any balance owed on my account regardless of the status of my insurance claims. I also understand the above information and guarantee this form was completed to the best of my knowledge and understand that it is my responsibility to inform the office of any changes in my personal and medical information.

Patient's (Parent or Guardian's) signature: ____ Date: _______