

Welcome to the Dynamic Chiropractic Clinic of Bellevue

15650 NE 24th St. Suite E , Bellevue, WA 98008 ; Tel: 425.827.BACK (2225)

Date: _____ Email: _____ Home Phone: _____

Name: _____ Sex: _____ DOB: _____ Age: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Sec #	Occupation	Company Name	Location	Work Phone #
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Guardian/Spouse Full Name	Guardian/Spouse DOB	Guardian/Spouse Employer	Location	Work Phone #
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Emergency Contact: _____ Relationship: _____ Phone: _____

Who referred you to this office? _____

Is your visit due to a car accident or work accident? Yes No (if yes, please see receptionist for an injury report)

Are you here for a massage? () No () Yes If so, have you ever received a professional massage? () No () Yes

Whom of your family or friends would you like to gift a free exam to ? (\$120 Value) _____

YOUR PRESENT COMPLAINT: _____

BRIEFLY DESCRIBE YOUR SYMPTOMS: _____

List other doctor (s) seen for this condition: _____

Personal Medical History (if any of the following are relevant to your medical history, please circle)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Venereal Disease |

Describe any operations you have had: _____

Have you been treated by a physician for any health condition in the last year? Yes No
Describe Condition _____ Date of the last physical exam _____

Are you now taking any medications? () No () Yes What kind? _____

Are you allergic to any medications? () No () Yes What kind? _____

Are you pregnant? Yes No Date of last menstrual period? _____

Do you have insurance? Yes No Company _____

ID Number _____ Policy Group Number _____

We invite you to discuss with us any questions regarding your care and our services. The best results are based on a friendly, mutual understanding between provider and patient. I hereby authorize the doctors, therapists, and whomever they designate as assistants to administer treatment as they deem necessary. I also authorize the provider and /or managed care organization to release my information required to process insurance claims. I 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: _____