Pure Wellness Chiropractic

3307 Evergreen Way, Suite 601 Washougal, WA 98671 P: 360.835.9911 F: 360.835.5765

Patient Information

Thank you for choosing Pure Wellness Chiropractic for your chiropractic needs. Please complete this form in ink.
If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.
(please print clearly)

Name: _____ Date: _____

Address: _____City: _____State: _____Zip Code: _____

Sex at birth: ☐ Female ☐ Male Birthdate: _____E-mail:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Do you prefer to receive calls at: ☐Home ☐Work ☐Cell

Marital Status: _____ Do you have children? ☐No ☐Yes, how many? _____

Patient Employer/School: _____Occupation:_____

Employer/School Address: _____City: _____State: _____Zip Code: _____

Spouse or parent's name: _____Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (_____)_____

Address: _____City: _____State: _____Zip Code: _____

Name of employer: _____ Work Phone: (_____)_____

Do you have health insurance? Yes No Name of Company: _____

Symptoms

Reason for visit: _____When did you first notice the symptoms? _____

Nature of Injury: ☐ Automobile ☐ Work ☐Other: _____

Is the condition getting progressively worse? _____Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐Stiffness ☐ Swelling ☐Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant, frequent, occasional or does it come and go?_____

Are your symptoms worse in the: ☐Morning ☐Afternoon ☐Evening ☐During the night

What treatment have you received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other: _____

Name and address of other doctor(s) who have treated you for your condition: _____

Health History Check only those conditions which are applicable:

☐ Alcoholism	☐ Allergies	☐ Anemia	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Breast Lump	☐ Brochitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain/Conditions	☐ Cold Hands/Feet
☐ Constipation	☐ Cramps	☐ Depression	☐ Diabetes
☐ Digestion Problems	☐ Dizziness	☐ Ears Ring	☐ Emphysema
☐Epilepsy	☐ Fatigue	☐ Fractures	☐ Headaches
☐ Hernia	☐ Herniated Disc	☐ High Blood Pressure	☐ Hot Flashes
☐Kidney Disease	☐Loss of Memory	☐Loss of Balance	☐Loss of Smell
☐Loss of Taste	☐Multiple Sclerosis	☐Osteoporosis	☐Pacemaker
☐Prostate Issues	☐Sciatica	☐Shortness of Breath	☐Sleep Problems
☐Stroke	☐Thyroid Condition	☐Tuberculosis	☐Tumor
☐Ulcers	☐Other _____		

Primary Care Doctor: _____Dates of last exams: _____

(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth Control Pills? ☐ Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____Nutritional supplements (if any)? _____

Do you smoke? ☐ Yes ☐ No How much per day?_____

How much liquor do you consume weekly? _____How many caffeinated beverages do you consume daily? _____

Family History (circle all that apply)

Mother Side:

Heart Disease Cancer Diabetes Arthritis Autoimmune Disorder
Other:_____

Father Side:

Heart Disease Cancer Diabetes Arthritis Autoimmune Disorder
Other:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient