Derrick Family Chiropractic

3535 Martin Way E
Olympia, WA 98506
360.491-9135

Welcome!

About You…

Date _____

Name: _____ M.I. _____ M / F I prefer to be called: _____

Address: _____ City: _____ State: ____ Zip: _____

Birthdate: _____ Age: _____ SSN: _____ Height: _____ Weight: _____

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

How did you find us? _____ Employer: _____

Occupation / Job Description: _____ Email: _____

Marital Status: S M D Spouse's Name: _____ Spouse's Birthdate: _____

Reason For Your Visit…

Reason for this visit is a result of (please circle): Work, Sports, Auto, Trauma, Chronic

Explain what happened: _____

_____

Describe the pain & its location: _____

_____

When did this condition begin? _____

Is this condition getting worse in (circle): Intensity? Frequency? Duration?

Rate your pain (1-10): Headache _____ Neck _____ Midback _____ Lowback _____

Is this condition interfering with your (circle): Work? Sleep? Daily Routine?

Have you been treated for this condition by any other doctor? Yes /No

If so, Where? _____ When? _____ By Whom? _____

Have you ever been treated by a Chiropractor before? Yes / No How long ago? _____

Emergency Contact…

Whom should we contact? _____ Relation: _____

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

Insurance Info…

None ☐

Company Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Insured's SSN: _____ Insured's DOB: _____ Policy / Plan / Group #: _____

INSURED'S EMPLOYER: _____

PLEASE LET US COPY YOUR INSURANCE CARD AND INFORM US OF 2ND INSURANCE SOURCE.
INSURANCE COVERAGE IS NOT A GUARANTEE OF PAYMENT. COVERAGE DEPENDS ON ELIGIBILITY AND PLAN PROVISIONS.

HEALTH HISTORY…

PATIENT NAME _____

PLEASE LIST ANY PRESCRIPTION OR OTC MEDICATIONS: _____

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS? (CIRCLE)

HEADACHES	CHEST PAIN	SEIZURE / EPILEPSY
NECK PAIN	DIFFICULTY BREATHING	HEART CONDITION
NUMBNESS / TINGLING	HIGH/LOW BLOOD PRESSURE	LIVER CONDITION
DIZZINESS / FAINTING	HIV / AIDS	HEPATITIS
MID BACK PAIN	CANCER	KIDNEY CONDITION
ARM / LEG PAIN	ASTHMA	FREQUENT URINATION
LOW BACK PAIN	ARTHRITIS	DIABETES
HIP PAIN	ARTIFICIAL JOINTS	FIBROMYALGIA / CHRONIC FATIGUE

OTHERS _____

LIST PREVIOUS SURGERIES/TRAUMAS/HOSPITALIZATIONS: _____

_____

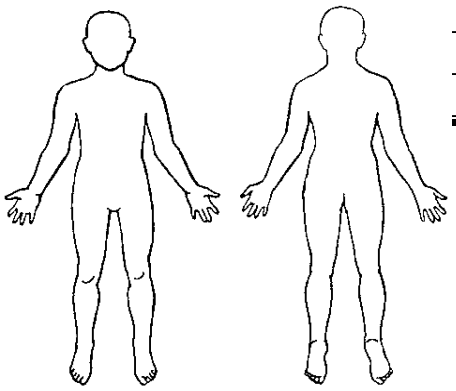
LIST PAST ACCIDENTS: _____

_____

DO YOU USE TOBACCO? YES / NO HOW MUCH? _____ HOW LO

DO YOU USE ALCOHOL? YES / NO HOW MUCH? _____ HOW LO

WOMEN: BIRTH CONTROL? YES/NO PREGNANT? YES/NO HOW LONG? _____



TO AID IN THE EVALUATION OF YOUR CONDITION, PLEASE MARK THE AREAS INVOLVING YOUR PAIN WITH THE FOLLOWING KEY:

P FOR PAIN
B FOR BURNING
A FOR ACHING
S FOR STABBING
N FOR NUMBNESS / TINGLING

WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.

OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IF ACCOUNT IS NOT PAID WITHIN A REASONABLE TIME AND NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT.

WE WILL ATTEMPT TO BILL YOUR INSURANCE OR RESPONSIBLE PARTY AS A COURTESY, HOWEVER, YOUR ACCOUNT IS YOUR RESPONSIBILITY.

I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

I AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED.

I UNDERSTAND THAT ALTHOUGH CHIROPRACTIC CARE HAS BEEN PROVEN TO BE SAFE AND EFFECTIVE, THERE ARE RISKS WITH ALL TYPES OF CARE. THESE RISKS MAY INCLUDE, BUT ARE NOT LIMITED TO, AGGRAVATION OF PAIN, TEMPORARY SORENESS, OR INEFFECTIVENESS. PLEASE ASK THE DOCTOR IF YOU HAVE FURTHER QUESTIONS.

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH OR PERSONAL STATUS.

SIGNATURE: _____ DATE: _____