Just For The Health of It
2402 Broadway Vancouver, WA 98663 (360)-241-6630

Patient Information Sheet (Please Complete both Sides):

Name: ____Age: ________DOB:____/____/________

Marital Status: ☐Married / ☐Partner / ☐Single / ☐Divorced / ☐Separated / ☐Widow

Address: ____

City: ________________________ State: _______________ Zip: ______________________________________

Home Phone:(____)____________Cell Phone:(____)_____________ Work Number:(____)________________

Email:____

Employer: ____Occupation:_______________________________

Brief Work Activity Description: ____

____

____

Nearest Relative: _________________Relation to you:_________________Phone Number: (____)__________

Emergency Contact: ____Phone Number: (____)__________

Referred By? ☐Website ☐Insurance List ☐Current patient:____________☐Event:___________☐Other:_____

Reason For this Visit? ☐Illness / ☐Injury / ☐Job related injury /☐Auto Accident / ☐Check-up/ ☐Other

How do you intend to pay? Cash / Credit Card / Insurance / Medicare / Worker's Compensation/ Auto Accident / Other? ____

(Filled Out by Office Manager, *Please give insurance card to front desk*):

Company: ____ Phone Number: (____)______________
Address:____
Patient ID:____Group Number:___________________________
Coverage:ND,LAC,LMT: ____
Xrays:__________________________________Orthotic:_____________Cervical Pillow:__________________
Deductable:____Copay:___________________
Referral Needed:________________________Notes:____

Please Read and Sign:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Just For the Health of It will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Just For the Health of It will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses including reasonable attorney fees. I hear by authorize the doctor to release information necessary to secure payment of benefits

Signature:____**Date**:_____/_____/_________________

Please Fill Other Side...................................

Patient Name______________________________ **DOB: / /**__________________

Injury Information:

What are your injuries or complaints?____

Who have you seen for them so far?____

When did they start?____

What activities aggravate your condition?____

Have you seen a chiropractor before? ☐No ☐Yes Year(s)____________________________

List Sport and Hobby Description and repeated Daily activities:________________________

List all Forms of exercise:____

How many glasses of water do you drink a day?________________________________

List Medications/Supplements:____

Previous Car Accidents? ☐No ☐Yes, Year(s)________________________________

Serious Illnesses/Hospitalizations/Surgeries? ☐No ☐Yes __________________________

Please check the appropriate boxes:

Now	Past		Now	Past		Now	Past		Now	Past	
☐	☐	Dizziness	☐	☐	Sciatica	☐	☐	Tuberculosis	☐	☐	Difficulty Breathing
☐	☐	Headache	☐	☐	Spinal Curvatures	☐	☐	Bruise Easily	☐	☐	Pleurisy
☐	☐	Allergies	☐	☐	Swollen Joints	☐	☐	Hay fever	☐	☐	Cancer
☐	☐	Depression	☐	☐	Colon Trouble	☐	☐	Nosebleeds	☐	☐	Itching
☐	☐	Knee Pain	☐	☐	Difficult Digestion	☐	☐	Sinus Infections	☐	☐	Varicose Veins
☐	☐	Ankle Pain	☐	☐	Hemorrhoids	☐	☐	High blood pressure	☐	☐	Bed-Wetting
☐	☐	Hip Pain	☐	☐	Asthma	☐	☐	Low blood pressure	☐	☐	Frequent Urination
☐	☐	Numbness	☐	☐	Deafness	☐	☐	Pain Over Heart	☐	☐	Kidney Infections
☐	☐	Tingling	☐	☐	Ear Noises	☐	☐	Poor Circulation	☐	☐	Prostate Trouble
☐	☐	TMJ Pain	☐	☐	Enlarged Thyroid	☐	☐	Rapid Heart Beat	☐	☐	Cramps/Backache
☐	☐	Anemia	☐	☐	Stroke	☐	☐	Chest Pain	☐	☐	Excessive Menses
☐	☐	Alcoholism	☐	☐	Diabetes	☐	☐	Polio	☐	☐	Hot Flashes
☐	☐	Fatigue	☐	☐	Ulcers	☐	☐	Bursitis	☐	☐	Rashes/Skin Lesions

List Typical Breakfast Foods:____

List Typical Lunch Foods:____

List Typical Dinner Foods:____

List Typical Snacks and Beverages____

List Hours of Sleep____________________Tobacco Use:________Cups/Coffee:________

List all types of exercise____________________Alcohol:__________Drugs:________

Consent to Treatment

I the undersigned being 18 years of age or older, give my consent to examination and treatment as deemed necessary and acceptable, understand that there are risks involved in the treatment of the spine and associated structures.

Patient Signature:______________________________**Date:**______________

I the undersigned parent/or person having legal custody/guardianship of the above named minor, do hereby authorize and consent to any x-ray, examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor of this office. This authorization shall remain in effect until revoked by the undersigned parent/guardian.

Parent/Guardian Signature:______________________________**Date:**______________