Cascadia Wellness Clinic

Confidential Patient Information

Name____ Date__________________

Address____

City_________________________ State___________ Zip___________________

Home Phone_______________ Cell Phone______________ Work Phone_______________

Email____________________________ Would you like to receive information via email? Y N

Date of Birth_______________ Sex M F SS#_____________ Marital Status M S W D

Spouses Name ___________________________ # of Children______________________

Emergency Contact (not living with you)____

Address____ Phone_________________

Parent or Legal Guardian if under 18____

Address if different than above____

Employer____ Phone____________________

Address____

Job Title____

How did you hear about our office?____

Current Condition

Present Complaints____

____

On a scale of 1-10, please rate the severity of your symptoms (10 is most severe) _________________

When did this condition begin?____

Have you had or been treated for same or similar condition before? Yes No

Describe____

Have you ever seen a chiropractor before? Yes No Who?___________________________

Have you seen another doctor about your present symptoms? Yes No

Name________________________________ Treatment______________________________

Have you been hospitalized for this condition? Yes No When_______________________

Hospital____

List medications you are taking____

List supplements you are taking____

____

Please complete reverse side

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Injury Information

Is your condition the result of an accident/injury? Yes No Date___________________________

Describe____

Were you hurt on the job? Yes No Describe____

____

Are you covered by Worker's Compensation? Yes No

Do you have a claim open? Yes No Where?__________________ Claim #________________

Are you unable to work due to present condition? Yes No Since___________________________

Are you experiencing other restrictions due to present condition? Yes No

Describe____

Health History

Have you had any major surgeries? Yes No Please indicate date(s) and procedures:

____

Have you had any prior injuries or accidents? Yes No Please give date(s) and descriptions:

____

Please indicate any other health problems below. Circle **C** for current, **P** for past and **F** for family.

Heart or Circulatory Problems	C	P	F	____________________
Digestive or Bowel Problems	C	P	F	____________________
Respiratory Problems	C	P	F	____________________
Eye, Ear, Nose Throat Problems	C	P	F	____________________
Tooth or Jaw Problems	C	P	F	____________________
Skin Problems	C	P	F	____________________
Allergies	C	P	F	____________________
Numbness or Tingling	C	P	F	____________________
Confusion or Depression	C	P	F	____________________
Kidney or Urinary Problems	C	P	F	____________________
Recurrent Infections/Fevers	C	P	F	____________________
Arm or Leg Pain	C	P	F	____________________
Back or Neck Pain	C	P	F	____________________
Menstrual Problems	C	P	F	____________________
Prostate Problems	C	P	F	____________________
Cancer	C	P	F	____________________

Other____

Comments____