CONFIDENTIAL HEALTH INFORMATION

PERSONAL DATA **DATE** ________________

Name ________________ Phone Res. ____________ Phone Bus. ____________

Address ____
(Street) (City) (State) (Zip)

SS# ________________ Washington Driver's License # ________________

Spouse ________________ Spouse's Employer ________________ No. Children ____

Emergency Contact Person ________________ Phone ________________

Who referred you here? Phone Book ☐ Newspaper ☐ Sign ☐ Friend ☐ Other ________________

HEALTH HISTORY

What significant health problems have you had in the past? ________________

What accidents, falls, injuries (even minor ones) have you had? ________________

Have you ever broken or fractured any bones? ☐ Yes ☐ No Describe how it occurred: ________________

What surgeries or operations have you had? (Include dates) ________________

Drugs or medications you take:

- ☐ Aspirin ☐ Pain Medication ☐ Muscle Relaxants ☐ Anti-Inflammatory
- ☐ Anti-Depressant ☐ Tranquillers ☐ Birth Control Pills

IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS, PLEASE CHECK
1 = MILD 2 = MODERATE 3 = SEVERE

1	2	3	Symptom
( )	( )	( )	EYE PAIN
( )	( )	( )	NAUSEA
( )	( )	( )	IRRITABILITY
( )	( )	( )	DIZZINESS
( )	( )	( )	FAINTING
( )	( )	( )	FATIGUE
( )	( )	( )	HEADACHES
( )	( )	( )	LOSS OF SLEEP
( )	( )	( )	NERVOUSNESS
( )	( )	( )	NUMBNESS
( )	( )	( )	SINUS PROBLEMS
( )	( )	( )	FREQUENT COLDS

1	2	3	Symptom
( )	( )	( )	LEG PAIN (Rt / Lt)
( )	( )	( )	LOW BACK PAIN
( )	( )	( )	WEAKNESS IN ARMS (Rt / Lt)
( )	( )	( )	BACKACHE
( )	( )	( )	POSTURE PROBLEMS
( )	( )	( )	FOOT TROUBLE (Rt / Lt)
( )	( )	( )	PAIN BETWEEN SHOULDERS
( )	( )	( )	PAINFUL TAILBONE
( )	( )	( )	SPINAL CURVATURE
( )	( )	( )	STIFF NECK
( )	( )	( )	NECK PAIN

1	2	3	Symptom
( )	( )	( )	CHEST PAIN
( )	( )	( )	DIFFICULT BREATHING
( )	( )	( )	NECK STIFFNESS
( )	( )	( )	HEART PROBLEMS

WOMEN ONLY			
( )	( )	( )	MENSTRUAL CRAMPS
( )	( )	( )	MENSTRUAL BACKACHE
( )	( )	( )	HOT FLASHES
( )	( )	( )	PREMENSTRUAL TENSION
	Y	N	ARE YOU PREGNANT?

INSURANCE INFORMATION

Name of Insured ______________________________

Name of Insurance Company ______________________________ Phone No. ______________

Address ______________________________

Insured's ID # ______________ Insured's Date of Birth ______________

Are you covered by Medicare? ☐ No ☐ Yes: Medicare# ______________

Payment is expected at time of visit unless other arrangements are made!
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Castle Chiropractic will prepare any reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to Castle Chiropractic will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to my account and I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Signature ______________________________ Date ______________

Guardian's Signature Authorizing Care ______________________________ Date ______________