



**Sound  
Health  
Chiropractic**

**Dr. David Cox**

**2401 15<sup>th</sup> Street Anacortes, WA 98221**

**360-299-4500**

**PATIENT INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: C- \_\_\_\_\_ H- \_\_\_\_\_ W- \_\_\_\_\_

Cell phone carrier \_\_\_\_\_ for appointment text reminders

Sex: F \_\_\_\_\_ M \_\_\_\_\_ Date of birth: \_\_\_\_\_

Divorced \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Single \_\_\_\_\_ Widow(er) \_\_\_\_\_

Occupation: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relationship to patient: guardian / parent \_\_\_\_\_ self \_\_\_\_\_ spouse \_\_\_\_\_ other \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Whom may we thank for referring you: \_\_\_\_\_

Is your condition due to an accident: NO \_\_\_\_\_ YES \_\_\_\_\_

If so, what type Vehicle \_\_\_\_\_ Work-related \_\_\_\_\_ Other \_\_\_\_\_ Date of Injury \_\_\_\_\_

**ASSIGNMENT & RELEASE**

I certify that I have insurance coverage and assign directly to Sound Health Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

I authorize Sound Health Chiropractic to release any information, including the diagnosis and the records, of any treatment or examination rendered to me or my dependent for the periods of such chiropractic care to third party payers and/or health practitioners.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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@HEALTH REPORT

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

Reason for seeking care: \_\_\_\_\_

List any other doctors/therapists seen for this: \_\_\_\_\_

List any diagnosis and type of treatment: \_\_\_\_\_

Have you had similar accidents or injuries before?  Yes  No If yes, explain: \_\_\_\_\_

Have you received chiropractic treatment previously?  Yes  No

If yes, explain: \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year?  Yes  No

If yes, explain: \_\_\_\_\_

Are you currently taking medication?  Yes  No List medications: \_\_\_\_\_

Have you taken medication in the past?  Yes  No List medications: \_\_\_\_\_

List conditions you are taking medications for: \_\_\_\_\_

List the approximate dates of any surgery or treated conditions: \_\_\_\_\_

Family History: Health conditions, age of death and cause of death.

Father: \_\_\_\_\_

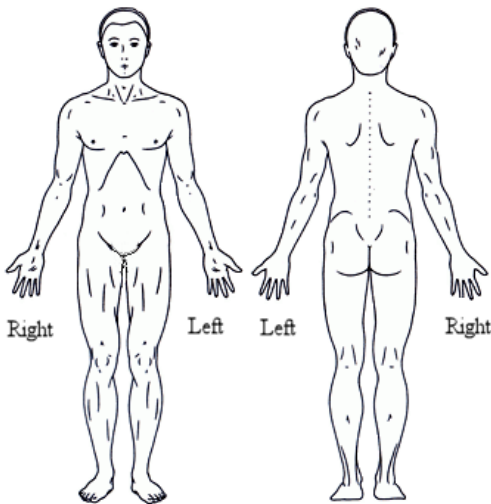
Mother: \_\_\_\_\_

Brother/s & Sister/s: \_\_\_\_\_

Do you smoke Y/N \_\_\_\_ • Alcohol Y/N  Daily  Weekly  Social Occasions • Caffeinated drinks per day \_\_\_\_

Do you take Vitamins/Supplements Y/N If yes, type and how often \_\_\_\_\_

Please circle degree of pain, 0 = none, 10 = severe: 0 1 2 3 4 5 6 7 8 9 10 Using the symbols



below, mark on the pictures where you feel:

Numbness = = =      Sharp/Stabbing / / /  
Dull Ache O O O      Pins and Needles + + +  
Burning X X X      Other \_\_\_\_\_ ^ ^ ^

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is this condition worse during certain times of the day? Y / N

Is this condition interfering with Work? \_\_\_\_\_ Sleep? \_\_\_\_\_

Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition progressively getting worse? \_\_\_\_\_

Do you experience pain with: Standing • Walking • Sitting

• Bending • Lying down • Lifting • Sports • Other \_\_\_\_\_

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\*\*Please mark each item below for each sign or symptom  
you presently have or previously had:

**GENERAL SYMPTOMS**

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

**MUSCLES & JOINTS**

- Low Back Problems
- Pain between  
Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

**CARDIO-VASCULAR**

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

**EAR/NOSE/THROAT**

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

**GASTRO-INTESTINAL**

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

**RESPIRATORY**

- Asthma

- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

**GENITO-URINARY**

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

**SKIN OR ALLERGIES**

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy

**FOR WOMEN ONLY**

- Birth Control \_\_\_\_\_
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## TERMS OF ACCEPTANCE

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain that goal. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and skeletal misalignment. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)