



Dr. David Cox

2401 15th 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: _____

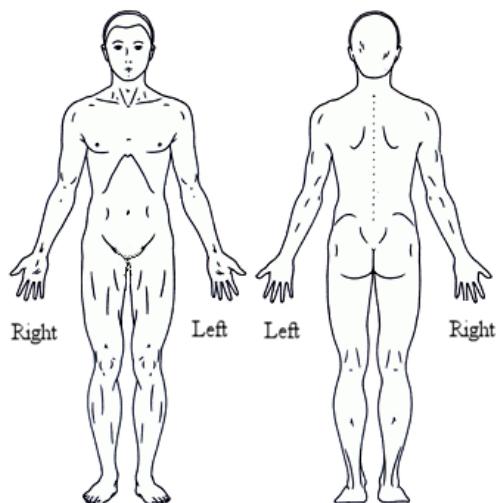
Do you smoke Y/N • Alcohol Y/N Daily Weekly Social Occasions • Caffeinated drinks per day

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 OOO	Pins and Needles + + +
Burning XXX	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

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)