Dr. David Cox **Sound Health Chiropractic** **(360) 299-4500**
1510 B Avenue, Anacortes, WA 98221

PATIENT INFORMATION

Name:____

Addess:____

City:__________________________ State:_________________________ Zip:____________

Phone: C-_____________________ H-_____________________ W-___________________

Sex: F____ M____ Date of birth:______________________

Divorced_____ Married_____ Separated_____ Single____ Widow(er)_____

Occupation:____

MEDICARE

Name on Medicare Card____

Medicare Number____

MESSAGING

I authorize SHC to leave messages with scheduling or medical information on the answering machine or voice mail at the following number(s):

Phone: Cell __________________ Home ____________________ Work_________________

I give SHC permission to leave medical or scheduling information with the following individuals if I am unavailable or in the case of an emergency:

____

Name Cell Home

____

Name Cell Home

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: ____

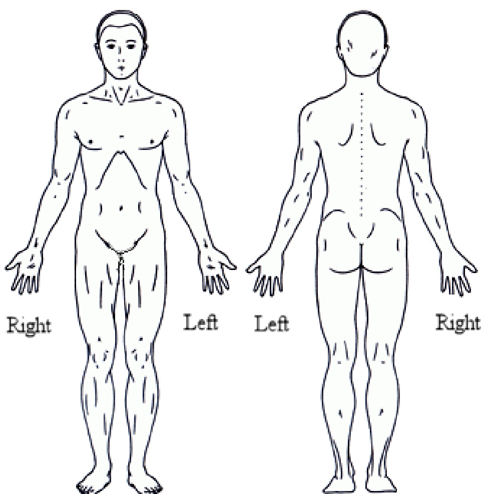
Brother/s & Sister/s: ____

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)