Long Chiropractic Center

5901 Roosevelt Way N.E. Suite #101-A
Seattle, WA 98105

DATE_____

Name_____Home Phone (_____)_____

E-mail address_____Cell Phone(_____)_____

Address_____City_____ST_____ZipCode_____

Age _____ Birthdate_____ Sex: M or F Marital Status: S M W D

How many children? _____Social Security #_____

Occupation_____Employer_____

Employer Address _____Office Phone (_____)_____

Name of Spouse (or responsible part if minor) _____

Occupation _____ Employer_____

Social Security # _____ Office Phone (_____)_____

Patient's Nearest Relative (not at same address)_____

Address _____ Phone (_____) _____

REFERRED BY _____

THIS OFFICE VISIT IS DUE TO

_____Car accident _____ On job injury _____Other accident _____ General

If insured claim, name of Company _____

Insured Name_____ _____Self _____Spouse ____Parent

Policy or Group # _____

Address of Company _____ Phone (____) _____

Secondary Insured Name _____ _____Self _____ Spouse ____Parent

Policy or Group # _____

Address of Company _____ Phone (____) _____

PRESENT COMPLAINTS

1. _____ How long?_____
2. _____ How long? _____
3. _____ How long? _____

Have you received other treatment for this condition? Y or N

If yes, who? _____ where? _____

ACCIDENTS/FALLS/OTHER INJURIES

Past auto accidents Y or N How recent _____Treatment Y or N

Past work injuries Y or N How recent _____ Treatment Y or N

Other injuries Y or N How recent _____ Treatment Y or N

Have you received chiropractic care before? Y or N

If yes, who? _____ where? _____

FAMILY HISTORY

NAME	PRESENT SYMPTOMS	PREVIOUS ILLNESS
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last menstrual cycle _____ Are you pregnant? Y or N

GENERAL SYMPTOMS

Circle any you have or have had in the past year

Headache:	Visual Problems	Pain between Shoulders
Sinus/Tension/Migraine	Hearing Problems	Muscle Spasms
Dizziness	Ear Infections	Hip Pain
Allergies	Loss of Sleep	Sciatica
Asthma	Neck Pain	Difficulty Breathing
Numbness or Pain in:	Neck Stiffness	Digestive Problems
Arms/Hands/Legs/Feet	Back Pain	Menstrual Problems

I hearby state that the information on all pages of this form is true and correct. I authorize Long Chiropractic Center to examine, take x-rays, treat me, and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Long Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Long Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient/Spouse/Guardian Signature _____ Date _____