
Confidential Health History



Today's Date: _____

Name: _____ SSN: _____ Age: _____

Email: _____ I would like appointment reminders by: text email
Cell phone provider (eg. Verizon, ATT): _____

Address: _____ Gender: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Employer: _____

Work Phone: _____ How did you hear about us? _____ Marital Status: _____

Emergency Contact Name: _____ Home Phone: _____

Is your visit due to an auto or work related injury? Yes No **If yes, stop here and see front desk!**

List authorized person(s) for medical information release: _____

Primary reason for seeking care? _____

Problem started on: _____ Most recent aggravation: _____

What makes it worse? _____

What makes it better? _____

Quality of symptoms:

Aching Burning Numbness/Tingling Stabbing Dull Deep Superficial

If symptoms radiate to other areas, where? _____

Mark Symptoms

No Pain 1 2 3 4 5 6 7 8 9 10 Incapacitating Pain

How frequent is it?

Constant(100%) Frequent(75%) Intermittent(50%) Occasional(25%)

How long does it last?

24hrs/day (wakes you at night) 16hrs/day (does not wake you) Other: _____ hrs/day

HT: _____ in. WT: _____ lbs Hobbies/Sports: _____

List medications: _____

Other providers used for healthcare: _____

Previous chiropractor(s): _____

All surgeries and dates: _____

Do you have insurance? Yes No **If yes, please give your card to the front desk**

Doctor's Notes Only

Initial: _____
Daily: _____ Cerv _____
4xs : _____ Consul _____
Lum: _____
3xs : _____ Adj: _____
2xs : _____ Extr: _____
1x : _____ F/U: _____
Consul _____
E-O : _____ Traction: _____
Mth : _____ Exer: _____

Pain Index Questionnaire

In the last (week/month),

How many days did you *miss (work or school)* due to (this health problem)? __

How many days did you *reduce your normal activities* due to (this health problem)? __

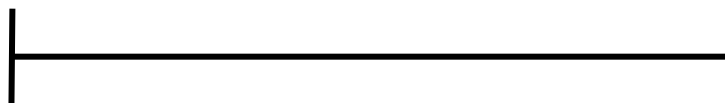
How many days did you *stay in bed more than half a day* due to (this health problem)? __

How many days have you felt very healthy and full of energy? __

Global Well Being Scale

Please think about your general sense of health and well-being. On the line below, make a straight line (up-and-down) to show how you feel right now.

WORST YOU
COULD
POSSIBLY FEEL



BEST YOU
COULD
POSSIBLY FEEL

Numeric Rating Scale

On a scale of 0 to 10, where "0" is "no pain" and "10" is the worst pain imaginable, please check the number that represents your pain right now.

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Specific Activities

(use activity limitation scale for each one.)

Are there activities you can't do or have trouble doing due to this health concern? Please list.
(examples: breastfeeding, sleeping, eating, crawling, walking, playing, going to school, etc.)

Activity Limitation

How much did this health concern limit your daily activities in the last week?

Activities are not limited 0 1 2 3 4 5 6 7 8 9 10 Can't do daily activities at all

Client Name (please print) _____

Date _____

Client or Guardian Signature _____

Notice of Privacy Practices, Terms of Acceptance and Office Policies

I, _____ have read and agree with the associated pages in regards to my care with Clear Chiropractic Spokane and have read the attached pages. (Pages present in office and copies are available upon request.)

_____ (initial) I have read and agree with the **Notices of Privacy Practices** and understand that it is required by law to maintain the privacy and confidentiality of your protected information. You have the right to a paper copy of this Notice of Privacy practices upon request.

_____ (initial) I have also read and agree with the **Terms of Acceptance**. I understand that the only practice objective at Clear Chiropractic is to eliminate a major interference to the expression of the body's innate wisdom. This method is specific adjusting to correct vertebral subluxations.

_____ (initial) I have read and agree with the Clear Chiropractic **Office Policies**. Our office requires at least 24 hours of notice so that the provider may see others in need. It is recommended that all missed appointments be made up later in the same day or within 7 days to help you stay on track with your health care goals. **NOTICE:** Any appointments missed without proper notification, will be subject to a **(\$25/Chiropractic)** fee due at your next visit. You are always able to call and leave a message outside of office hours to reschedule.

I have read and fully understand the above statements.

Print Name: _____ Date: _____

Signature: _____

Print Name: _____ Date: _____

(Guardian name if under 18)

Your health is of the utmost importance to us, and we want you to get the most out of your chiropractic care. If you have any questions, about office policies or appointments, DO NOT hesitate to ask. We are here for you!