



**CONFIDENTIAL PATIENT INFORMATION**

Date: \_\_\_\_\_

**PERSONAL:**

NAME \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
(First and last name) (M or F) mo. day yr. (Area code) Number

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
(Include street type, such as St., Ave., etc.)

Social Sec. # \_\_\_\_\_ Occupation \_\_\_\_\_ Company Name \_\_\_\_\_ Location \_\_\_\_\_ Business Phone Number \_\_\_\_\_

Spouse's First Name \_\_\_\_\_ Spouse's Soc. Sec. # \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Location \_\_\_\_\_

NAME OF NEAREST RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

IS YOUR VISIT DUE TO AN ACCIDENT?  NO  YES (If yes, please see receptionist for Injury Report)

PRESENT COMPLAINT \_\_\_\_\_

BRIEFLY DESCRIBE SYMPTOMS \_\_\_\_\_

LIST OTHER DOCTOR(S) SEEN FOR THIS CONDITION \_\_\_\_\_

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION?  NO  YES (If yes, please describe) \_\_\_\_\_

DESCRIBE THE OPERATIONS YOU'VE HAD: \_\_\_\_\_ WHEN? \_\_\_\_\_

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR?  NO  YES

DESCRIBE CONDITION: \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM \_\_\_\_\_

ARE YOU NOW TAKING ANY MEDICATION?  NO  YES WHAT KIND? \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION?  NO  YES WHAT KIND? \_\_\_\_\_

ARE YOU PREGNANT?  NO  YES DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

INSURANCE DATA (Clinic policy requires payment arrangements to be made on the first visit)

DO YOU HAVE INSURANCE?  NO  YES INS. COMPANY NAME \_\_\_\_\_

I.D. NO. \_\_\_\_\_ POLICY GROUP NO. \_\_\_\_\_

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF, FURTHERMORE, I UNDERSTAND THAT THIS OFFICE 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 THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE CO-INSURANCE REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT, HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE, UNLESS PRIOR ARRANGEMENT ARE MADE. I HEREBY AUTHORIZE THE DOCTORS AT YAKIMA/WEST VALLEY CHIROPRACTIC CENTRES AND WHOMEVER THEY MAY DESIGNATE TO ADMINISTER TREATMENT AS THEY SO DEEM NECESSARY AND ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRE IN THE COURSE OF MY EXAMINATION OR TREATMENT. I AGREE TO PAY 1% PER MONTH (12% ANNUAL) INTEREST ON UNPAID BALANCES GREATER THAN 90 DAYS OLD. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

PATIENT'S SIGNATURE \_\_\_\_\_

PARENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

**Medicare Lifetime Authorization**

I request that payment of authorized Medicare benefits be made on my behalf to the Yakima/West Valley Chiropractic Centres for any services furnished to me by their physicians. I authorize the release of medical information about me to the CMS (Center for Medicare and Medicaid Services) and its agents any information needed to determine the benefits payable for services provided.

PATIENT'S SIGNATURE \_\_\_\_\_

If any of the following are relevant to your health history, please circle **Y**. If yes, please circle **now** if it is a current or recent problem or **ever** if it is a past problem and not currently bothering you.

			For office use only			
Y/N	HEADACHES	DOLOR DE CABEZA (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	DIZZINESS	MAREOS (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	FATIGUE	CANSANCIO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	WEIGHT LOSS	PÉRDIDA del PESO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	NIGHT PAIN	DOLOR en la NOCHE (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	FAINTING	DESMAYO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	VISION	LAVISTA (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	ALLERGIES	ALERGIAS (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	SINUS	SINUSITIS (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	HEART	CORAZON (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	CHEST PAIN	DOLOR del PECHO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	PALPITATIONS	PALPITACIONES (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	BLOOD PRESSURE	PRESION de la SANGRE (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	DIABETES	DIABETES (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	LUNGS	LOS PULMONES (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	STOMACH	EL ESTOMAGO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	KIDNEY	LOS RIÑONES (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	LIVER	EL HIGADO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	MENSTRUAL	MENSTRUAL (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	URINARY	ORINAR (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	CONSTIPATION	ESTREÑIMIENTO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	DIARRHEA	DIARREA (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	LEG PAIN	DOLOR de PIERNA (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	ARM PAIN	DOLOR del BRAZO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	NUMBNESS	ENTUMECIMIENTO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	NECK PAIN	DOLOR del CUELLO (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	MID-BACK PAIN/DOLOR EN EL MEDIO dela ESPALDA	(now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	LOW BACK PAIN DOLOR en la PARTE BAJADE la ESPALDA	(now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	SHOULDER PAIN	DOLOR de CINTURA (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	HIP PAIN	DOLOR DE LA CADERA (now, ever)	Onset_____	Freq._____	Dur._____	Int._____
Y/N	SURGERY	CIRUGIAS	_____			
Y/N	FRACTURES	FRACTURAS	_____			
Y/N	CAR ACCIDENT	ACCIDENTE de AUTOMOVIL	_____			
Y/N	WORK INJURY	ACCIDENTE deLA TRABAJO	_____			
Y/N	OTHER HISTORY		_____			