REDMOND ROOTS CHIROPRACTIC NEW PATIENT INTAKE

Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home telephone: ( ) _____ Work: ( )_____ Cell: ( ) _____
Email Address: _____ Male: _____ Female: _____
Social Security Number: _____ Birth Date: _____ Age: _____
Occupation: _____
Employer Name and Address: _____
Single: _____ Married:_____ Spouse's Name: _____
Insurance: Primary _____ Secondary: _____ Do you have an HAS or an FSA? Amt $:
Have you seen a chiropractic before? Yes _____ No _____ If yes, when? _____
Who may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ✓ Check all symptoms you have ever had, even if they do not seem related to your current problems

- ○ Headaches
- ○ Pin and Needles in arms
- ○ Dizzness
- ○ Numbness in fingers
- ○ Fatigue
- ○ Sleeping problems
- ○ Cold sweats
- ○ Mood Swings
- ○ Pin and Needles in legs
- ○ Loss of smell
- ○ Buzzing in ears
- ○ Numbness in toes
- ○ Depression
- ○ Neck Stiff
- ○ Constipation
- ○ Lights bother eyes
- ○ Menstrual Pain
- ○ Fainting
- ○ Back pain
- ○ Ringing in ears
- ○ Loss of taste
- ○ Irritability
- ○ Cold hands
- ○ Fever
- ○ Problem urinating
- ○ Menstrual irregularity
- ○ Neck Pain
- ○ Loss of balance
- ○ Nervousness
- ○ Stomach upset
- ○ Tension
- ○ Cold feet
- ○ Hot flashes
- ○ Heartburn
- ○ Ulcer

Main Complaint: _____
List any medications you are taking: _____
Have you been in a car crash (fender bender)? Yes No If so, When? _____
This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____
The statements made on this form accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation _____
Patient Signature: _____ Date: _____
Guardian Signature: _____ Date: _____

15965 NE 85th ST. Suite 202. Redmond, WA. 98052

Phone: (425) 968-2262