Terry Family Chiropractic

Dan Terry, D.C.

4340 Pacific Hwy, Ste 103
Bellingham, WA 98226
Telephone: (360) 527-9722
Fax: (360) 527-2713

PATIENT INFORMATION

Date:_____ Patient Name: (Last, First, Initial): _____
Mailing Address:_____
(City) (State) (Zip Code)

Date of Birth:_____ Patient SS#:_____ Height:_____ Weight:_____
Gender: ☐Male ☐Female ☐Single ☐Married ☐Widowed ☐Divorced
Primary Care Doctor:_____ Employer:_____ Occupation:_____
Spouse's Name:_____ Spouse's Employer:_____ Number of Children:_____
Whom may we thank for referring you? _____

PHONE NUMBERS
Home: _____ Work:_____ Cell:_____
Best time and place to reach you? _____

CONTACT IN CASE OF EMERGENCY
Name:_____ Relation:_____
Home #:_____Work #:_____

Patient Appointment Reminders by ☐ Text, ☐Phone call, or ☐ Email _____

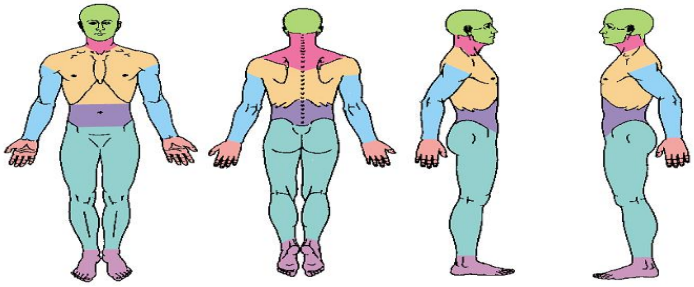
PATIENT CONDITION

Reason for Visit:_____ When did symptoms appear?_____
Is this condition getting progressively worse? ☐Yes ☐No Rate the severity of pain on a scale of 1 (least pain) to 10:___
How often do you have this pain?_____ Is it constant or intermittent?_____
Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other_____ **Does the pain interfere with:** ☐Work ☐Sleep ☐Daily Routines ☐Recreation
Activities that are painful to perform: ☐Sitting ☐Standing ☐Bending ☐Lying down

ACCIDENT INFORMATION

Is this condition due to an accident? ☐Yes ☐No Date of accident:_____ Date of onset of pain:_____
Type of Accident: ☐Auto ☐Work ☐Other_____ to who was the accident reported? ☐Auto Insurance ☐Employer ☐L&I ☐Other_____

Please mark an X on the picture where you have pain, Numbness or tingling.



INSURANCE INFORMATION

Person responsible for account:_____
Relationship to Patient:_____
Insurance Company:_____
ID#:_____ Group #:_____
Secondary Coverage? ☐Yes ☐NO
Insurance Co.:_____
ID#:_____ Group #:_____

INSURANCE INFORMATION

I understand, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Terry all insurance benefits, if any, otherwise payable to me for services redeemed. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dr. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

_____

Responsible Party's Signature Date

HEALTH HISTORY

What treatment have you already received for your condition? ○Medication ○Surgery
○Physical Therapy ○Chiropractic ○None ○Other _____
Name the above Doctor, Therapist or facility where you treated for your condition:
_____

Date of Last: Physical Exam_____ Spinal x-ray _____ Blood Test _____
Spinal Exam_____ Chest x-ray_____ Urine Test_____
MRI, CT-Scan, Bone Scan _____

Mark "L" or "R" for any you are currently having:

MusculoSkeletal

Headaches	○L	○R
TMJ	○L	○R
Neck Pain	○L	○R
Upper Back Pain	○L	○R
Shoulder Pain	○L	○R
Collar Bone Pain	○L	○R
Rib Pain	○L	○R
Chest/Stern	○L	○R
Arm/Elbow Pain	○L	○R
Wrist Pain	○L	○R
Hand Pain	○L	○R
Fingers	○L	○R
Mid Back Pain	○L	○R
Shoulder Blade	○L	○R
Low Back Pain	○L	○R
Tailbone	○L	○R
Sacroiliac	○L	○R
Hip Pain	○L	○R
Groin Pain	○L	○R

MusculoSkeletal (cont)

Leg Pain	○L	○R
Knee Pain	○L	○R
Ankle/Foot Pain	○L	○R
Toe Pain	○L	○R
Sciatica Pain	○L	○R

CardioVascular

Chest Pain	○L	○R
Short Breath	○L	○R
Blood Pressure	○L	○R
Heart Problems	○L	○R
Lung Problems	○L	○R
Congestion	○L	○R
Varicose Veins	○L	○R

Ear, Nose, Throat

Vision Problems	○L	○R
Ear Aches	○L	○R
Hearing Difficulty	○L	○R
Stuffed Nose	○L	○R

Nervous System

Nervousness	○L	○R
Numbness	○L	○R
Dizziness	○L	○R
Forgetfulness	○L	○R
Confusion	○L	○R
Depression	○L	○R
Fainting	○L	○R
Convulsions	○L	○R
Cold/tingling	○L	○R
Extremities	○L	○R

Female

Menstrual Irreg.	○L	○R
Cramps	○L	○R
Vaginal Pain	○L	○R
Breast Pain	○L	○R
Other problems	○L	○R

Male

Prostate	○L	○R
Other Problems	○L	○R

Genital-Urinary

Bladder Trouble	○L	○R
Painful Urination	○L	○R
Excessive Urination	○L	○R

General

Fatigue	○L	○R
Allergies	○L	○R
Loss of Sleep	○L	○R
Fever	○L	○R

Other_____
_____
_____
_____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
CAR ACCIDENTS		

Are you pregnant? ○Yes ○No Due Date:_____

Exercise
○None
○Moderate
○Daily
○Heavy

Work Activity
○Sitting
○Standing
○Light labor
○Heavy Labor

Habits
○Smoking
○Alcohol
○Coffee/Caffeine Drinks
○High Stress Level

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
_____	_____	_____
_____	_____	_____