burien wellness

Date: _____/_____/_____

Patient Information

Name: _____ Date of birth: _____/_____/_____

Street address: _____ City: _____

State: _____ Zip code: _____ Home phone: (_____)_____

Cell phone: (_____)_____ Would you like appointment reminders via text? ☐ Yes ☐ No

Cell phone provider (for text reminders): AT&T Verizon T-Mobile Sprint Other:_____

Email address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Spouse's name: _____ # of children: _____

Occupation: _____ Employer: _____

Emergency contact name / Phone: _____ / (_____)_____

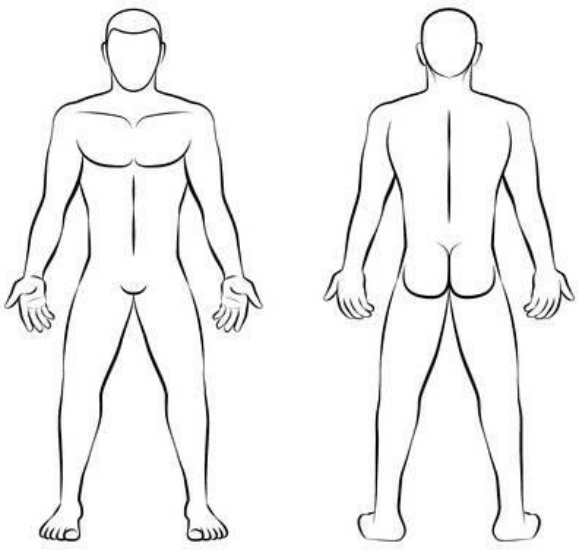
Whom may we thank for referring you? _____

Insurance provider: _____ Prefix and ID#: _____

Health Information

What is the reason for your visit? ☐ Wellness ☐ Physical Complaint ☐ Accident ☐ Other

1. Please mark below any of the following areas with physical complaints you are experiencing:



2. When did your symptoms begin?

3. What was the mode of onset?

4. Have you experienced these symptoms before?
☐ Yes ☐ No

5. Please rate your average level of pain on a scale of 0-10 (0=no pain, 10=worst pain ever): _____

6. Have you seen anyone else for this complaint?
☐ None ☐ Chiropractor ☐ Physical Therapist
☐ Specialist ☐ Other: _____

7. What happened as a result of treatment?
☐ Resolved ☐ Unresolved ☐ Worsened
☐ Improved, but not to acceptable level

8. Do you have a history of any of the following?
☐ Work-related injury ☐ Motor vehicle accident ☐ Slip and fall accident
If yes, please list approximate dates and incidents:
Incident: _____ Date: _____
Incident: _____ Date: _____

9. Have you ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, please list approximate dates and condition:
Condition: _____ Date: _____
Condition: _____ Date: _____

10. Do you have any of the following symptoms?

Headaches	Anxiety	Discharge from breast	Painful urination
General fatigue	Hearing trouble	Excessive vomiting	Chills
Night sweats	Pain in eyes	Loss of sleep	Fainting
Nervousness	Nose bleeds (chronic)	Dizziness	Phobias
Mood swings	Bleeding gums	Depression	Pain in ears
Vision trouble	Tonsillitis	Ringing in ears	Nose/sinus pain
Excessive drainage	Goiter	Eye discharge	Absence of smell
Mouth sores	Skin itching	Nasal infections	Absence of taste
Abnormal taste	Bruise easily	Enlarged glands	Heat/cold intolerance
Sugar in urine	Swollen extremities	Difficulty swallowing	Skin rash/Eczema
Redness of skin	Chest pain	Tremors	Hair changes
Nail changes	Prostate problems	Weight change	Chronic wheezing
Difficulty breathing	Bed-wetting	Convulsions	Varicose veins
Rapid heartbeat	Sterility	Memory loss	Heart murmur
Changes in appetite	Abnormal vaginal	Skin dryness	Hemorrhoids
Excessive gas	bleeding	Chronic cough	Excessive constipation
Heartburn/indigestion	Impotence	Blue extremities	Ear discharge
Frequent urination	Breast pain	Heart palpitations	Other:_____
Abnormal menstruation	Redness/itching of breast	Abdominal pain	_____
Lumps in breast	Dimpling of breast	Excessive diarrhea	_____

11. What are some of your current health goals/practices?

12. How do your current complaints influence your activities?

13. What activities are important to you?

14. What do you hope to gain from your time here?

15. Wellness is a balance of many factors. Starting in the center, color in your level of satisfaction in the following areas: