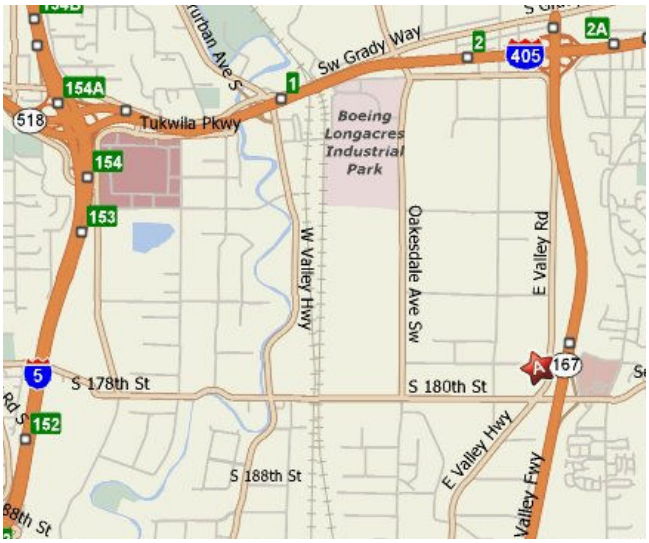
Baze CHIROPRACTIC

Welcome!

Thank you for your interest in BazeChiropractic.com
We hope that you like what you've read about our philosophy and patient care.
Call for your appointment today.
(425) 251-5715

You'll find us at…

200 SW 41st Street, Suite 100
Renton, WA 98057



From I-405 as you drive through Renton (either direction)
Take exit 2 onto Hwy 167 South (Valley Freeway) then follow directions below.

From Hwy 167 South (Valley Freeway)
Take the first exit at SW 41st Street.
Go straight at the stoplight onto SW 41st Street.
Turn into the first driveway on the right.

From Hwy 167 North (Valley Freeway)
Take the 180th Street exit.
Turn left at the light onto South 180th Street.
Take a right at the next light onto East Valley Road.
Take a left onto SW 41st Street.
Turn into the first driveway on the right.

Bring this <u>completed</u> Patient Information and Health History Form
to your new patient appointment and receive a

$25.00 Gift Certificate *

to be used on any of our services or supplies.
*Offer not valid with any other promotion.

Chiropractic Care
Massage Therapy
Personal Training
Fitness Center Membership
Pillows and Supports
Supplements and Healthy Snacks

Baze CHIROPRACTIC

Patient Information and Health History

TITLE	FIRST NAME M.I. LAST NAME	ALTERNATE/NICKNAME

ADDRESS	CITY STATE ZIP

HOME PHONE	WORK PHONE	CELL PHONE

E-MAIL	WOULD YOU LIKE A PHONE CALL THE DAY BEFORE YOUR APPOINTMENTS TO REMIND YOU OF APPOINTMENTS? ☐ YES ☐ NO

☐ MALE ☐ FEMALE	OCCUPATION	D.O.B.	AGE

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED	NO. OF CHILDREN	HEIGHT WEIGHT

NAME OF SPOUSE (FIRST & LAST)	SPOUSE OCCUPATION	SPOUSE EMPLOYER

EMPLOYER	EMPLOYERS PHONE
EMPLOYER'S ADDRESS	CITY STATE ZIP

EMERGENCY CONTACT NAME	PHONE

I WAS REFERRED TO THIS OFFICE BY:

PLEASE INDICATE IF YOU ARE SEEKING CARE AS THE RESULT OF:
☐ AN ON THE JOB INJURY ☐ AN AUTO ACCIDENT ☐ HOME INJURY DATE OF INJURY _____

WHAT ARE YOUR MAJOR COMPLAINTS?

1) 2) 3)

DO YOU KNOW WHAT HAPPENED TO CAUSE THE PROBLEM?

HOW LONG HAS IT BEEN BOTHERING YOU? (1) (2) (3)	HAS IT BOTHERED YOU BEFORE? (1) (2) (3)

IS IT GETTING ☐ BETTER ? ☐ WORSE ? ☐ STAYING THE SAME ?

WHAT ACTIVITIES AGGRAVATE IT?

WHAT HAVE YOU BEEN DOING FOR IT?

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ NO ☐ YES WHERE:

WHAT OTHER DOCTOR'S HAVE YOU SEEN FOR THIS PROBLEM? WHEN?

WHAT DID HE/SHE TELL YOU IS WRONG?

WHAT DID HE/SHE RECOMMEND?

DID YOU DO IT? ☐ NO ☐ YES WHAT WERE THE RESULTS?

WHO IS YOUR FAMILY PHYSICIAN?

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAMINATION?

NAME (S) OF OTHER DOCTORS THAT SEE YOU REGULARLY

HAVE YOU EVER HAD ANY FALLS, ACCIDENTS OR INJURIES? ☐ YES ☐ NO PLEASE EXPLAIN	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY
HAVE YOU EVER HAD SURGERY? ☐ YES ☐ NO PLEASE EXPLAIN	MONTH, YEAR	TYPE OF SURGERY	WHY WAS SURGERY PERFORMED?
PLEASE LIST ALL MEDICATION THAT YOU ARE PRESENTLY TAKING.	NAME OF MEDICATION	DOSES PER DAY	REASON FOR MEDICATION

PLEASE **CIRCLE** ANY OF THE FOLLOWING THAT BOTHER YOU **NOW**, i.e. (HEADACHES)

AND **CHECK** ANY OF THE FOLLOWING THAT HAS BOTHERED YOU IN THE **PAST** i.e. ☑ HEADACHES

- ☐ HEADACHES
- ☐ SHOOTING HEAD PAINS
- ☐ NECK PAIN OR STIFFNESS
- ☐ MUSCLE SPASMS IN NECK
- ☐ GRINDING IN NECK
- ☐ TIGHTNESS OF SHOULDERS & ARMS
- ☐ PAIN IN SHOULDERS & ARMS
- ☐ PINS & NEEDLES IN ARMS & HANDS
- ☐ NUMBNESS IN ARMS/HANDS/FINGERS
- ☐ COLD HANDS/FINGERS
- ☐ MID BACK PAIN OR STIFFNESS
- ☐ MID BACK MUSCLE SPASMS
- ☐ CHEST PAIN
- ☐ LOW BACK PAIN OR STIFFNESS
- ☐ LOW BACK MUSCLE SPASMS
- ☐ PAIN IN LEGS & FEET
- ☐ NUMBNESS IN LEGS
- ☐ NUMBNESS IN FEET
- ☐ PINS & NEEDLES IN LEGS
- ☐ PINS & NEEDLES IN FEET
- ☐ COLD FEET
- ☐ HIP PAIN OR STIFFNESS
- ☐ HIP PAIN OR STIFFNESS
- ☐ PAINFUL JOINTS
- ☐ SWOLLEN JOINTS
- ☐ SWOLLEN ANKLES
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ BLURRED VISION
- ☐ DIFFICULTY SWALLOWING
- ☐ THROAT FEELS SWOLLEN
- ☐ LOSS OF MEMORY
- ☐ DIZZINESS/ VERTIGO
- ☐ LOSS OF BALANCE
- ☐ FAINTING SPELLS
- ☐ LIGHTS BOTHER EYES
- ☐ IRRITABILITY
- ☐ ANXIETY
- ☐ NERVES & NERVOUSNESS
- ☐ DEPRESSION
- ☐ CHRONIC TIREDNESS
- ☐ SLEEPING PROBLEMS
- ☐ RINGING IN EARS
- ☐ TWITCHING OF FACE
- ☐ SHORTNESS OF BREATH
- ☐ SINUS TROUBLE
- ☐ ALLERGIES
- ☐ HAYFEVER
- ☐ ASTHMA
- ☐ THYROID TROUBLE
- ☐ FREQUENT EAR INFECTIONS
- ☐ FREQUENT COLDS
- ☐ FREQUENT SORE THROATS
- ☐ TONSILITIS
- ☐ PROSTATE TROUBLE
- ☐ CONSTIPATION / DIARRHEA
- ☐ KIDNEY / BLADDER TROUBLE
- ☐ MENSTRUAL CRAMPS/PAIN
- ☐ MENSTRUAL IRREGULARITY
- ☐ DIABETES
- ☐ HEART ATTACK (S)
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ ANEMIA
- ☐ STOMACH TROUBLE
- ☐ ULCERS
- ☐ INDIGESTION / HEARTBURN
- ☐ INTESTINAL GAS
- ☐ LOSS OF APPETITE
- ☐ HERNIA
- ☐ STROKE
- ☐ BED WETTING
- ☐ ARTHRITIS
- ☐ HEMORRHOIDS
- ☐ FREQUENT URINATION
- ☐ CANCER
- ☐ DECREASED LIBIDO
- ☐ REPRODUCTIVE DIFFICULTIES
- ☐ GOUT
- ☐ IMMUNE SYSTEM DISORDER
- ☐ ADD/ADHD
- ☐ LEARNING DISORDERS
- ☐ ANOREXIA / BULEMIA
- ☐ ALCOHOLISM
- ☐ DRUG / CHEMICAL DEPENDANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and I. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also acknowledge that I have received a copy of this office's notice of privacy practices.

Patient Signature_____ Date_____

Guardian or Spouse's
Name and Signature Authorizing Care_____