

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

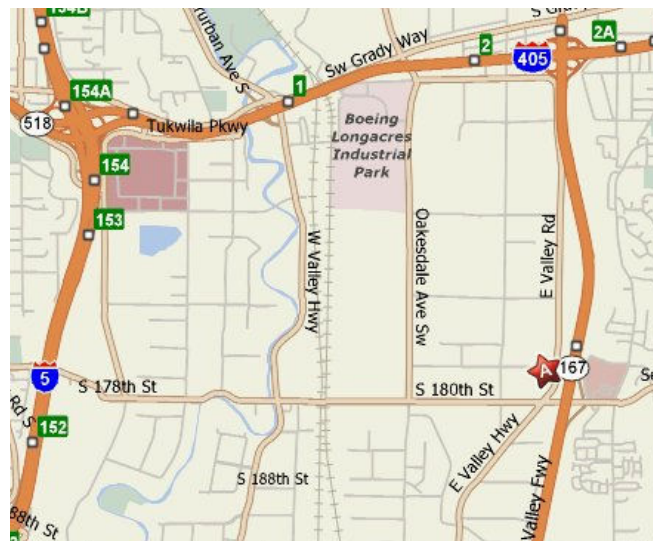
You'll find us at...

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 41<sup>st</sup> Street.  
Go straight at the stoplight onto SW 41<sup>st</sup> Street.  
Turn into the first driveway on the right.

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

**200 SW 41<sup>st</sup> Street, Suite 100  
Renton, WA 98057**



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

**\$25.<sup>00</sup> 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



## 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OCCUPATION			D.O.B.
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED <input type="checkbox"/> 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:				
<input type="checkbox"/> AN ON THE JOB INJURY <input type="checkbox"/> AN AUTO ACCIDENT <input type="checkbox"/> 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?      HAS IT BOTHERED YOU BEFORE?				
(1) _____ (2) _____ (3) _____			(1) _____ (2) _____ (3) _____	
IS IT GETTING <input type="checkbox"/> BETTER ? <input type="checkbox"/> WORSE ? <input type="checkbox"/> STAYING THE SAME ?				
WHAT ACTIVITIES AGGRAVATE IT?				
WHAT HAVE YOU BEEN DOING FOR IT?				
HAVE YOU HAD <input type="checkbox"/> NO CHIROPRACTIC CARE BEFORE? <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY
HAVE YOU EVER HAD SURGERY? <input type="checkbox"/> YES <input type="checkbox"/> 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

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

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 \_\_\_\_\_