BLUE LAKES CLINICS
Blue Lakes Chiropractic & Blue Lakes Medicine

PATIENT INFORMATION

Date:_____

Legal Name:_____ **Preferred Name:**_____

DOB:_____ **Social Security Number (For Billing Purposes Only):**_____

Mailing Address: _____

City:_____ **State:**_____ **Zip:**_____

Race: □White □Hispanic/Latino □Black/African American □American Indian/Alaska Native □Asian □Pacific Islander □Asian □Middle Eastern □_____ □Choose to not answer **Sex:** □M □F

Marital Status: □Never married □Married □Divorced □Separated □Widowed □Domestic Partners

Primary Phone: _____ Secondary Phone:_____

Email:_____

Business Employer:_____ **Phone:**_____

Emergency Contact:_____ **Phone:**_____

Relationship: _____

Who is your primary care provider? Name:_____ **Phone:**_____

How did you find us? □Insurance □Location □Phonebook □Internet □Facebook □Referral_____

INSURANCE INFORMATION

(Please give your insurance card & photo ID to the receptionist)

Person Responsible For Bill (if different):_____ **DOB:**_____

Social Security Number:_____ **Is This Person a Patient Here?** □Yes □No

Address (if different): _____

Employer:_____ Phone:_____

PRIMARY INSURANCE:_____

Group #:_____ **Policy #:**_____ **Co-payment:**_____

Subscriber's Name:_____ **DOB:**_____

Social Security Number (For Billing Purposes Only):_____

Patient's relationship to subscriber: □Self □Spouse □Child □Other_____

SECONDARY INSURANCE:_____

Group #:_____ **Policy #:**_____ **Co-payment:**_____

Subscriber's Name:_____ **DOB:**_____

Social Security Number (For Billing Purposes Only):_____

Checked____

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Name:_____ **Date:**_____

REASON FOR YOUR VISIT

Describe Your PRIMARY COMPLAINT:_____

_____

_____

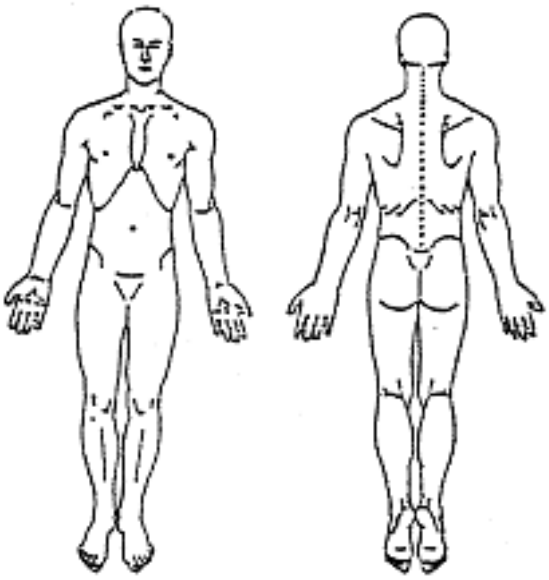
Describe Any OTHER COMPLAINT(S):_____

_____

When did it first begin?_____

What caused it? _____

_____



Please circle the severity of your complaints.

[----------]

0 1 2 3 4 5 6 7 8 9 10

How frequent is the complaint? □Daily □Weekly □Monthly (Indicate The Area Affected)

When is it worse? □AM □Noon □PM

Circle the % of time you have the complaint.

10% rarely 25%-occasionally 50%-intermittently 75% = frequently 100% = constantly

How is it affecting your life/profession/recreation/obligations?_____

_____

What makes it better?_____

What makes it worse?_____

Is there anything else we should know about this complaint?

Checked____

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Name:_____ **Date:**_____

MEDICAL HISTORY

Adrenal Dysfunction	□Yes □No	Irregular Heart Rhythm	□Yes □No
Alzheimer	□Yes □No	Kyphosis	□Yes □No
Amyotrophic Lateral Sclerosis	□Yes □No	Liver Dysfunction	□Yes □No
Anorexia or Bulimia	□Yes □No	Kidney Failure, or Dysfunction	□Yes □No
Anxiety Disorder	□Yes □No	Malignancy If yes, describe below	□Yes □No
Arteriovenous Malformations (AVMs)	□Yes □No		
Arthritis	□Yes □No		
Asthma	□Yes □No	Mania	□Yes □No
Autoimmune Disease	□Yes □No	Muscular Dystrophy	□Yes □No
Bipolar Disorder	□Yes □No	Myocardial Infarction (Heart Attack)	□Yes □No
Bleeding Disorder	□Yes □No	Narcolepsy	□Yes □No
Cataracts	□Yes □No	Obstructive Sleep Apnea	□Yes □No
Cerebrovascular Accident (Stroke)	□Yes □No	Organ Transplant (If yes, describe)	□Yes □No
Chemotherapy (If yes, state when)	□Yes □No		
		Osteoporosis	□Yes □No
Claudication	□Yes □No	Pancreatitis	□Yes □No
Clotting Disorder	□Yes □No	Periodic Limb Movement Disorder	□Yes □No
Congenital Heart Defects	□Yes □No	Peripheral Artery Disease	□Yes □No
Coronary Artery Disease	□Yes □No	Personality Disorder	□Yes □No
COPD	□Yes □No	Pituitary Dysfunction	□Yes □No
Cystic Fibrosis	□Yes □No	Polycystic Ovarian Syndrome	□Yes □No
Depression	□Yes □No	Pulmonary Artery Hypertension	□Yes □No
Diabetes	□Yes □No	Pulmonary fibrosis	□Yes □No
Dialysis	□Yes □No	Radiation Therapy, (if yes explain)	□Yes □No
Eclampsia or Pre-eclampsia	□Yes □No		
Endocarditis	□Yes □No	Recurrent Infections	□Yes □No
Endometriosis	□Yes □No	Restless Leg Syndrome	□Yes □No
End Stage Renal Disease	□Yes □No	Sarcoidosis	□Yes □No
Erectile Dysfunction	□Yes □No	Schizophrenia	□Yes □No
Esophageal Dysfunction	□Yes □No	Scleroderma	□Yes □No
Fibromyalgia	□Yes □No	Scoliosis	□Yes □No
Gallstones	□Yes □No	Seizure Disorder	□Yes □No
Gastritis or Gastric Ulcers	□Yes □No	Sickle Cell	□Yes □No
GERD (reflux problems)	□Yes □No	Sjogren	□Yes □No
Glaucoma	□Yes □No	Skin Disorder (Psoriasis, Acne)	□Yes □No
Heart or Valve Defects	□Yes □No	Thalassemia	□Yes □No
Hemochromatosis	□Yes □No	Thrombocytopenia	□Yes □No
Hemorrhoids	□Yes □No	Thrombophilia	□Yes □No
Hepatitis	□Yes □No	Transfusions	□Yes □No
HIV or AIDS	□Yes □No	Tuberculosis	□Yes □No
Hypertension	□Yes □No	If yes, have you been treated?	□Yes □No
Hyperthyroidism	□Yes □No	Urinary retention or urgency	□Yes □No
Hypotension	□Yes □No	Vasculitis	□Yes □No
Hypothyroidism	□Yes □No	Visual defects	□Yes □No
Inflammatory Bowel Disease	□Yes □No	Vocal cord dysfunction/paralysis	□Yes □No

Checked____

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Name:_____ **Date:**_____

MEDICAL HISTORY CONT'D

Please list all current medications you are taking. (Include OTC medications, herbs & vitamins.)

Medication	Dose	Last taken	Medication	Dose	Last taken

Please list Food, Medication or Insect Allergies and describe your reaction_____

_____

Please list all previous surgeries.

Procedure & Date	Surgeon	Procedure & Date	Surgeon

Do you exercise? □ Yes □No If yes, how long and how often you exercise each week?_____
Have you ever smoked? □Yes □No # packs per day_____X_____# years **Chewing tobacco?** □Yes □No
Have you quit? □Yes □No **Have you considered quitting?** □Yes □No **Have you set a date?** □Yes □No
Do you now, or did you once, regularly drink alcohol? □Yes □No # _____drinks per □Day □Week
Do you now use, or have you ever used, drugs for recreational purposes? □Yes □No
If yes, check all that apply: □Amphetamines □Cocaine □Marijuana □Heroin □Inhalants □LSD
Describe the method you used: □Ingestion □ Injection □Inhalation Have you quit? □Yes □No
Have you ever had a problem with addiction to Rx pain medication or benzodiazepines? □Yes □No
Can you perform your own hygiene, dressing, cooking and shopping needs independently? □Yes □No
Have you ever been in a relationship where you were threatened, hurt or afraid? □Yes □No

Family Medical History

Family Member Affected	Medical Problem(s)

Female Patients Only

Have you ever been pregnant □Yes □No ___# of pregnancies ___# Live Births ___# Miscarriages
____Age at onset of menstruation _____Age at onset of menopause □NA
Have you ever taken birth control pills, or used patches or implants? □Yes □No If yes, how long_____
Have you ever used hormone replacement therapy? □Yes □No If yes, how long_____

Checked____