BLUE LAKES CHIROPRACTIC & MEDICINE CLINICS

PATIENT INFORMATION

Date:_____

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

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

Mailing Address: _____

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

Primary Phone:_____ Secondary Phone:_____

Cell Phone:_____ **Email:**_____

Work Phone:_____ **Employer:**_____

May we send texts, emails, or voice messages regarding: □Appointments □Care □Test Results

How May We Contact You? □Text □Email □Voice Select Best Voice Number □Home □Cell □Work

Emergency Contact:_____ **Phone:**_____

Relationship: _____ May we discuss your care with them? □Yes □No

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 Care Provider Name:_____ **Phone:**_____

Preferred Pharmacy:_____ **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:_____

Checked____

BLUE LAKES CHIROPRACTIC & MEDICINE CLINICS

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 complaint.

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

0 1 2 3 4 5 6 7 8 9 10

How frequent is the complaint? □Daily □Weekly □Monthly **How Often?** □Off & On □Constant

How is it affecting your life?

What makes it better? **What makes it worse?**

Is there anything else we should know about this complaint?

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

Please list all previous surgeries.

Checked____

BLUE LAKES CHIROPRACTIC & MEDICINE CLINICS

Name:_____ **Date:**_____

MEDICAL HISTORY

Alzheimer	□ **Yes**	**Hemorrhoids**	□ **Yes**
Anxiety Disorder	□ **Yes**	**Hepatitis**	□ **Yes**
Arteriovenous Malformations	□ **Yes**	**HIV or AIDS**	□ **Yes**
Arthritis	□ **Yes**	**Hypertension**	□ **Yes**
Asthma	□ **Yes**	**Hyperthyroidism**	□ **Yes**
Autoimmune Disease	□ **Yes**	**Hypercholesterolemia**	□ **Yes**
Bipolar Disorder	□ **Yes**	**Hypothyroidism**	□ **Yes**
Cerebrovascular Accident (Stroke)	□ **Yes**	**Inflammatory Bowel Disease**	□ **Yes**
Chemotherapy / Radiation Therapy	□ **Yes**	**Irregular Heart Rhythm**	□ **Yes**
Clotting Disorder	□ **Yes**	**Kidney Failure, or Dysfunction**	□ **Yes**
Congenital Heart Defects	□ **Yes**	**Malignancy / Cancer**	□ **Yes**
Coronary Artery Disease	□ **Yes**	**Myocardial Infarction (Heart Attack)**	□ **Yes**
COPD	□ **Yes**	**Obstructive Sleep Apnea**	□ **Yes**
Cystic Fibrosis	□ **Yes**	**Osteoporosis / Osteopenia**	□ **Yes**
Depression	□ **Yes**	**Pancreatitis**	□ **Yes**
Diabetes	□ **Yes**	**Peripheral Artery Disease**	□ **Yes**
Eclampsia or Pre-eclampsia	□ **Yes**	**Polycystic Ovarian Syndrome**	□ **Yes**
Endometriosis	□ **Yes**	**Recurrent Infections**	□ **Yes**
Erectile Dysfunction	□ **Yes**	**Restless Leg Syndrome**	□ **Yes**
Esophageal Dysfunction	□ **Yes**	**Stroke / TIA**	□ **Yes**
Fibromyalgia	□ **Yes**	**Scoliosis**	□ **Yes**
Gallstones	□ **Yes**	**Seizure Disorder**	□ **Yes**
Gastritis or Gastric Ulcers	□ **Yes**	**Skin Disorder (Psoriasis, Acne)**	□ **Yes**
GERD (reflux problems)	□ **Yes**	**Urinary retention or urgency**	□ **Yes**
Heart or Valve Defects	□ **Yes**	**Visual defects**	□ **Yes**

Family Medical History

Family Member	Living	Medical Problem(s)
Father	□Yes □No	
Mother	□Yes □No	

Have you ever smoked / chewed / vaped? □Yes □No ___# packs per day X ___# years
Have you quit? □Yes □No **Have you considered quitting?** □Yes □No
Do you now, or did you once, regularly drink alcohol? □Yes □No
Have had a problem with addiction to Rx pain medication or benzodiazepines? □Yes □No
Have you ever been in a relationship where you were threatened, hurt or afraid? □Yes □No

Female Patients Only

Are you pregnant □Yes □No ___ # Weeks ___# pregnancies ___# Births ___# Miscarriages

Checked____