Griffith Chiropractic Clinic, P.C.

CHIROPRACTIC ACUPUNCTURE MASSAGE

"Try natural first..."

Registration Date: _____

Patient Name: _____
Last First Middle Initial Nickname if preferred

Address: _____
Street Apt # City State Zip

Date of Birth: _____ Age: _____

Please provide phone numbers for which we have permission to leave a voicemail;

Cell Phone: _____ Cell Phone Provider: (i.e. AT&T) _____

Home Phone: _____ Work Phone: _____

Preferred method for appointment reminders (Circle one): Email / Phone / Text

E-mail Address: _____

Is it okay if we send you an occasional health e-newsletter or specials? Yes No

Your employer: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about our office? _____

Financial & Insurance Information

Health Insurance Company: _____

Does your policy cover chiropractic? Yes No Massage? Yes No

Name of Primary Person Insured: _____ Insured's Date of Birth: _____

Relationship to you: _____

Your Auto Insurance Company: _____

PIP Claim Number: _____ Date of Injury: _____ State Occurred _____

Adjuster's Name: _____ Adjuster's Phone Number: _____

Worker's Compensation Company: _____

Claim Number: _____ Date of Injury: _____ State Occurred _____

Claim Manager's Name: _____ CM's Phone Number: _____

Attorney's Name: _____ Attorney's Phone Number: _____

Chief Complaint

Name: _____ Date: _____

Describe your complaint/problem: _____

_____

_____

Is your condition due to an accident (Circle One)? No Auto Work Home Other _____

How long have you had this condition? _____

What seemed to be the initial cause? _____

Is it getting worse? Yes No **Does it bother...** Work Sleep Other_____

What makes the problem (feel) better? _____

What makes the problem (feel) worse? _____

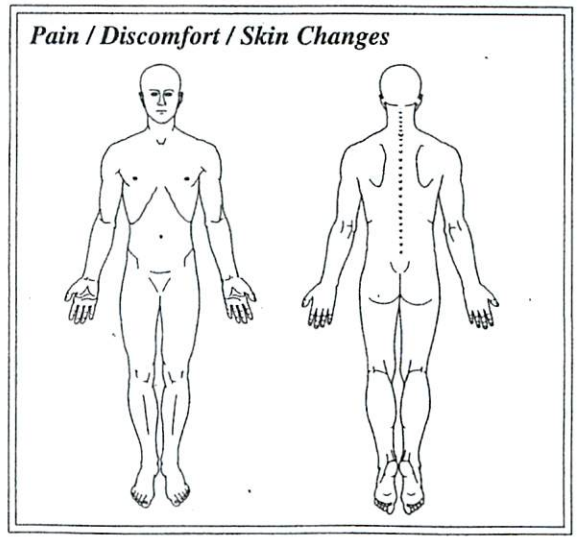
Have you been treated for this problem? _____ By whom? _____

1) Shade the area(s) where your pain occurs on the diagram to the right

2) Use the following scale to indicate your current pain in the areas you shaded. Please write the number next to the areas you marked on the chart.

0-10 Pain Scale:

0	No Pain
1-3	Mild
4-6	Moderate
7-9	Severe
10	Worst Possible



Please do not write in this area (LOCQSMAT):

_____

_____

_____

_____

_____

_____

_____

Griffith Chiropractic Clinic, P.C. • 3305 Main Street, Suite 100 • Vancouver, WA 98663
Phone (360) 693-8064 • Fax (360) 693-7206 • www.trinaturalhealthcare.com

Health History

Name: _____ Date: _____

What is your occupation? _____ Do you enjoy your job? Yes No

Primary Care Physician: _____ **Clinic:** _____

Do you have a history of high blood pressure? Yes No

Do you exercise? Yes No If Yes, how much? _____

Circle any of the following conditions you have had or currently have:

Alcoholism
Allergies
Anemia
Aneurysm
Appendicitis
Arteriosclerosis
Arthritis
Articular derangements
Atrophy in the extremities
Bone weakening
Bowel movement changes/problems
Cancer
Chicken Pox
Cholera
Circulatory or cardiovascular disorder
Cold Sores
Congenital connective tissue disorder
Constipation
Degenerative joint disease
Diabetes
Diarrhea
Diptheria
Disc degeneration
Eczema
Edema / Swelling
Emphysema
Epilepsy
Fainting
Fatigue / Malaise, unexplained
Fever (current)
Flu (current)
Fracture or dislocation
Gout
Heart disease
Headaches
Herniated disc
High blood pressure
Infection (current)
Joint pain/anomaly
Loss of weight, unexplained
Malaria
Multiple sclerosis
Muscle weakness
Neurological disorder
Numbness
Osteoporosis
Pacemaker
Painful menstruation
Pregnancy *If currently pregnant, due date:* _____
Rectal bleeding
Scoliosis
Spinal canal stenosis
Spondylolisthesis
Stroke
Thyroid disease
Tingling
Tuberculosis
Vertebrobasilar insufficiency
Vertigo
Other_____

List any serious accidents, injuries or traumas in your life time:_____

_____

_____

List any serious health conditions, hospitalizations or surgeries you have had in your life time:

_____

_____

_____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

Name: _____ Preferred Language: _____

Family Medical History ***(List any diseases than run in your family and check the affected relative)***				
Diagnosis *Example: Heart Disease*	Father	Mother *X*	Sibling	Grandparent

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only (highlight abnormal findings)

Age: _____ Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ Smoke: Y/N

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