

# ABOUT THE PATIENT

DesRoches Chiropractic, PLLC  
10709 N DIVISION ST | SPOKANE, WA 99218

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birth-date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Gender  M  F

Significant Other's Name \_\_\_\_\_ Kid's Names and Ages \_\_\_\_\_

Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_

e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before?  Yes  No

Emergency Contact \_\_\_\_\_ PH # \_\_\_\_\_

Name of Medical Doctor(s) \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize DesRoches Chiropractic to release and/or request records to/from other providers as necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:  Cash  Check  Credit Card  Car/Work Ins.

\_\_\_\_\_  
Patient/ Parent Signature (This represents a long-term authorization for all occasions of service) Date

# REASON FOR SEEKING CARE

**PRESENT COMPLAINTS**

Neck \_\_\_/10; At Worst \_\_\_/10; At Best \_\_\_/10 Is the pain: Left Right Center How long has this been an issue? \_\_\_\_\_

Is it:  Dull  Sharp  Ache  Numb/Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

Mid-Back \_\_\_/10; At Worst \_\_\_/10; At Best \_\_\_/10 Is the pain: Left Right Center How long has this been an issue? \_\_\_\_\_

Is it:  Dull  Sharp  Ache  Numb/Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

Low-Back \_\_\_/10; At Worst \_\_\_/10; At Best \_\_\_/10 Is the pain: Left Right Center How long has this been an issue? \_\_\_\_\_

Is it:  Dull  Sharp  Ache  Numb/Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

Extremities \_\_\_\_\_/10; At Worst \_\_\_/10; At Best \_\_\_/10 Is the pain: Left Right Center  
 How long has this been an issue? \_\_\_\_\_

Is it:  Dull  Sharp  Ache  Numb/Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

5. Does your condition affect:  Sleep  Work  Daily Routine  Sitting  Driving

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

8. What Doctor's have you seen for this? \_\_\_\_\_

9. Type of treatment: \_\_\_\_\_

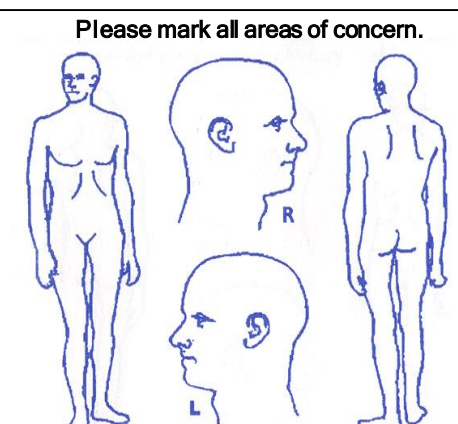
10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_

**Are you pregnant?**

Yes  No

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

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Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

## Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other \_\_\_\_\_

## Past Present

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- \_\_\_High or \_\_\_Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications you are taking: \_\_\_\_\_

2. Please list all doctors you are currently seeing: \_\_\_\_\_

3. Has any Doctor or other professional advised you to "Go to a Chiropractor":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

4. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_

5. List any past work injuries: \_\_\_\_\_ Was any care received? \_\_\_\_\_

6. List any past sport, recreational, or home injuries \_\_\_\_\_

7. Please describe any past conditions and treatment received: \_\_\_\_\_

8. Please list any past hospitalizations and surgeries: \_\_\_\_\_

## FAMILY HISTORY

Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_

Is there any other family history you want us to know? \_\_\_\_\_

# OFFICE POLICY

DesRoches Chiropractic, PLLC  
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## SPINAL CHECK-UP:

- We recommend everyone have their spine checked yearly for spinal problems. Prevention is the best medicine.
- Children especially, to see if their spine is developing abnormally? A spinal check-up is easy and fun for kids.

## WE ALSO OFFER:

- Supplement advice and nutritional/exercise counseling.  
*Please ask if you have any questions about these services!*

## AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- **\$25** no show fee if we are not notified at least **24 hours** before your scheduled appointment.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great!

Patient: \_\_\_\_\_ Date \_\_\_\_\_ Staff \_\_\_\_\_