

Vancouver Chiropractic

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NAME _____ DOB ____/____/____ TODAY'S
DATE ____/____/____

PHONE (HOME) _____ (WORK) _____ (CELL) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ EMAIL _____ PRIMARY PHYSICIAN _____

EMPLOYER _____ OCCUPATION _____ SSN _____

DO YOU HAVE INSURANCE _____ IF YES, PLEASE GIVE CARD TO RECEPTIONIST

Reason for today's visit and current symptoms _____

Date of injury / onset of symptoms _____

Describe how condition started _____ Has this happened
before Y N

Has your condition been treated before Y N Any diagnostic testing (MRI, X-Ray, lab work) _____

What has worked in the past? (medications, therapy, etc.) _____

List any medications/herbs and doses you are currently taking _____

Spinal surgeries Y N If yes, list all and years _____

Do you suffer from headaches Y N Location _____

How long do they last _____ Times per week/month _____

Conditions you have been diagnosed as having: Anxiety Diabetes
Depression
Bleeding Disorder Arthritis Stroke Asthma Gout High
Blood Pressure
Memory Loss Heart Attack Kidney Stones Ringing in ears Anemia Thyroid
Disease
Fractures: (describe) _____

Other: _____

Is there anything else we may be able to help you with _____

Who can we thank for referring you _____ Have you been to a chiropractor before
Y N

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Notice of Privacy

We keep a record of the health care services provided. You may ask to see and receive a copy of that record. You may also seek to have the record corrected. This information will not be disclosed to others unless under your direction or as required by law.

The Privacy Notice (available for review at the Front Desk) explains this information in great detail.

My signature below signifies that I have read and understand the Privacy Notice provided.

Patient Name (please print) _____

Signature of Patient/Parent/Legal Guardian _____

Date _____