BAKKE CHIROPRACTIC CLINIC 5220 Pacific Avenue Tacoma, WA 98408 (253) 472-3365	**General History Form**

Dec 2012

Welcome to Bakke Chiropractic Clinic

Enjoy our state of the art services including DRX disc decompression and professional massage to improve your health.

Patient Information

Patient First Name	Patient Last Name	M.I.	Gender □M □F	Age	Date of Birth (MM/DD/YYYY) / /
Patient Address		Unit #	City	State	Zip
Home Phone	Cell Phone	Work Phone	Marital Status □S □M □Widowed □Separated □Divorced		

Would you like a reminder of your appointments via text or telephone? □ Yes □ No

Occupation	Employer Name	Email Address	Social Security Number – –
Work Address	City	State	Zip

Have you seen a chiropractor before? □ Yes □ No Referred by □ Internet □ Telephone book □ Insurance list □ friend/family

May we ask your family or friend name? _____

Emergency Contact Information (Person who does NOT live with you)

First Name	Last Name	Phone Number

Additional Information (*Fill out the following only if the patient is COVERED*)

Spouse's or Parent's First Name	Spouse's or Parent's Last Name	M.I.	Gender □M □F	Age	Date of Birth (MM/DD/YYYY) / /
Occupation	Employer Name	Work Phone Number	Social Security Number – –		
Work Address			City	State	Zip
Insurance Company		Insurance Policy Number	Insurance Group Number		

Assignment Authorization Agreement Power of Attorney Agreement

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable to and mailed to:
   Bakke Chiropractic Clinic 5220 Pacific Avenue Tacoma, WA 98408 (253) 472 3365
   If my policy prohibits assignments, then check should be payable to me and sent to above address.
2. I authorize the office to release any information to any insurance company, adjuster, or attorney that will assist in the payment of my health services claim.
3. I appoint this office as attorney-in-fact to correspond on my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Attorney's-- Counsel, insurance companies, and negligent parties be advised that, no settlement can be effectuated without the agreement of this office or the offices' release of this provision. Said negotiation to be for the payment of health expenses and will not release negligent party from other responsibilities. The office does not intend to "represent" me in any way, this appointment is strictly to prevent negligent parties, attorneys or insurance companies from settling any financial relations with me the patient without fulfilling my financial responsibilities to this office first.
4. I fully understand and agree that insurance polices are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.
5. If the office incurs any attorney fees or other collection expenses for the collection of this account because I have not complied with this agreement, I understand that I will be responsible for those fees or expenses in addition to the health care fees.
6. I understand for automobile PIP or third party claims or personal injury claims that Bakke Chiropractic Clinic does not bill or accept payment from HMO or major medical health insurance.
7. A finance charge of 9% per year or .0075% per month will be added on accounts with balances over 90 days unless other financial arrangements are made.

Date Reviewed & Signed	Patient or Guardian Signature
Responsible party	Information Taken By

Is illness or injury related to □Work □Auto □Other	Do you have other insurance that might cover the injury/illness? □Yes □No	If yes, Please list other insurance company name:

Please list your reason(s) for the visit or your condition(s) in order of importance	Date you first noticed:	Using a scale in which "0" is **none** (no pain or symptom) and "10" is **severe** pain or symptom(s). Circle the number that best reflect your condition:
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10
4. _____	_____	0 1 2 3 4 5 6 7 8 9 10
5. _____	_____	0 1 2 3 4 5 6 7 8 9 10

For reasons or conditions listed above, please mark how it happened:

□ Developed over time □ Illness □ Injury □ Auto Accident □ I don't know □ Other _____

Date and time of your present injury? _____

Present injury (ies) please describes. What happened?

_____

What were you doing at the time of injury? _____

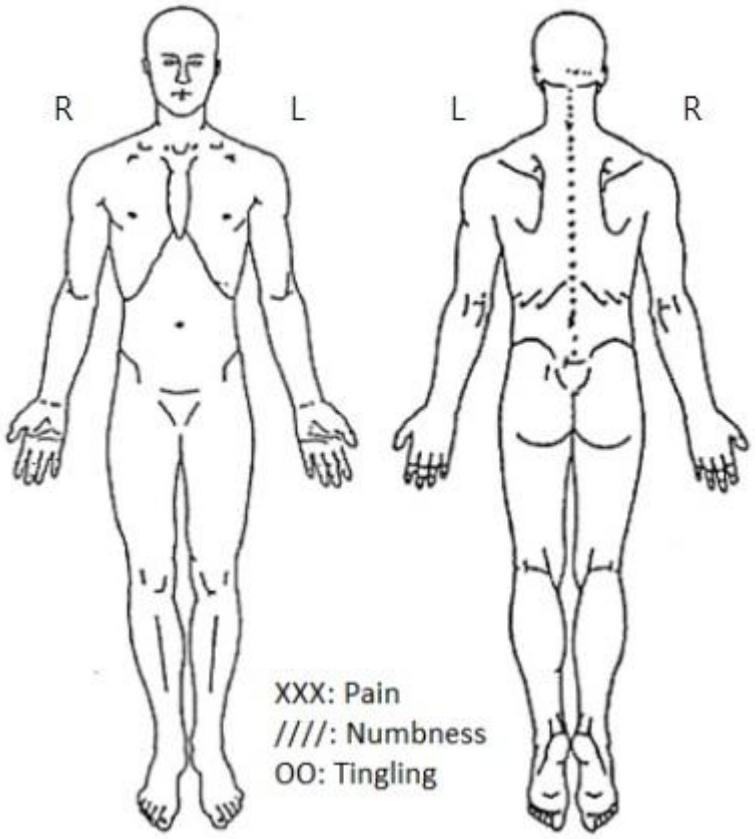
Where did your injury take place? _____

How long since your injury? _____

For reason listed above, please check if it is better or worse with any if the following:

	HEAT		COLD		REST		ACTIVITY		OTHER		
	better	worse	better	worse	better	worse	better	worse	better	worse	
Reason 1	□	□	□	□	□	□	□	□	□	□	_____
Reason 2	□	□	□	□	□	□	□	□	□	□	_____
Reason 3	□	□	□	□	□	□	□	□	□	□	_____
Reason 4	□	□	□	□	□	□	□	□	□	□	_____
Reason 5	□	□	□	□	□	□	□	□	□	□	_____

Please Mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:



Please check the box that best describes whether your pain or symptom(s) limit normal activities due to this accident or injury:

Activity	Normal	Somewhat limited	Severely limited
Lifting	□	□	□
Bending	□	□	□
Standing	□	□	□
Sitting	□	□	□
Walking	□	□	□
Running	□	□	□
Climbing stairs	□	□	□
Dressing or undressing	□	□	□
Resting in bed	□	□	□
Getting out of bed	□	□	□
Computer working	□	□	□
Reading	□	□	□
Intercourse	□	□	□
Household activities	□	□	□
Normal work	□	□	□
Other			
_____	□	□	□
_____	□	□	□
_____	□	□	□

Past History

Have you had accident or injuries? □ Yes □ No If yes, please list type of accident and date
1. _____ (_____) 2. _____ (_____) 3. _____ (_____)

Have you ever had any broken bones before? □ Yes □ No If yes, please indicate location and date
1. _____ (_____) 2. _____ (_____) 3. _____ (_____)

Have you had any surgical procedure? □ Yes □ No If yes, please indicate type of surgery and date
1. _____ (_____) 2. _____ (_____) 3. _____ (_____)

Have you had any childhood, adult ilness or disease? □ Yes □ No If yes, please list them and date
1. _____ (_____) 2. _____ (_____) 3. _____ (_____)
4. _____ (_____) 5. _____ (_____) 6. _____ (_____)

Have you been diagnosed as having HIV exposure? □ Yes □ No If yes, indicate when diagnosed? (_____)

Family History

What is the status Father's health? What is the status Mother's health?

If they have (had) a disease, please mark all (F:Father M: Mother)

□ Autoimmune disorder (F/M) □ Cancer (F/M) □ Heart disease (F/M) □ Mental illness (F/M)
□ Arthritis (F/M) □ Diabetes (F/M) □ Kidney disease (F/M) □ Seizure (F/M)

Present History

Are you currently taking any prescription or over-the-counter-medicine? □ Yes □ No If yes, please list them and how long taken
1. _____ (_____) 2. _____ (_____)
3. _____ (_____) 4. _____ (_____)

Do you have any medication or over-the-counter-medication allergies? □Yes □No If yes, please list type of allergy
1. _____ 2. _____
3. _____ 4. _____

Do you have any other allergies? □ Yes □ No If yes, please list type of allergy
1. _____ 2. _____
3. _____ 4. _____

Are there injuries which you have been treated for this past years? □ Yes □ No If yes, how did you respond?
_____

Please list your primary medical doctor	Doctor name		Clinic name	
Clinic Address	Unit #	City	State	Zip

Social History

Are you taking illegal drugs? □ Yes □ No If yes, please list type of drug and frequency of use per week
1. _____ (_____) 2. _____ (_____)

Do you smoke? □ Yes □ No If yes, please list frequency of use per week : _____

Do you drink alcohol? □ Yes □ No If yes, please list number of times per week: _____

Do you exercise? □ Yes □ No If yes, please list type of exercise and frequency of per week
1. _____ (_____) 2. _____ (_____)

Height: _____ Weight: _____

Women ONLY

Are you pregnant? □ Yes □ No □ Possibly

Do you take birth control pills? □ Yes □ No If yes, when did you take last time: (___/___/___)

Do you take aspirin currently? □ Yes □ No If yes, when did you take last time: (___/___/___)

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practictioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature of Patient	Date	Signature of Witness	Date