CONFIDENTIAL PATIENT INFORMATION

Name_____Home Phone_____

Cell phone_____ Email address_____

Address_____ City_____State_____Zip_____

Age_____ Birth date_____ Marital Status ___M ___S ___D___W Number Of Children_____

Your Occupation_____Employer_____

Employer Address_____ Work Phone _____

Name Of Spouse/Parent_____ Their Employer_____

Referred By_____

Emergency contact not living with you_____

Their relationship to you_____ Their phone_____

Symptoms we are seeing you for_____

_____

Are your symptoms worse in the ____ morning ____during the day ____evenings ____ night ____same all day

Rate the severity of your worst symptom (circle) No pain 1 2 3 4 5 6 7 8 9 10 unbearable pain

What makes your symptoms better_____worse_____

Other doctors seen for this condition_____

List any surgeries you have had and date_____

_____

List any major illnesses you have had and date_____

_____

List any medications you are taking_____

If female are you pregnant _____ no _____ yes If yes, due date_____

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS BILLING INSURANCE

Do you have health insurance _____no _____yes Social security number_____

Primary insurance name_____ Secondary Ins_____

Who is insured_____ Relationship_____

Person responsible for payment_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that Lembke Chiropractic Clinic will assist me in making collections from the insurance company, I authorize that payment from the insurance companies for services at this office be made directly to Lembke Chiropractic Clinic. However I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in full. I also authorize the release of my medical records to my present or future insurance company.

Patient's Signature_____ Date_____

Information Taken By _____Date_____

Review of Systems

Have you had or do you have any of the following conditions? ***(check only those that apply)***

Presently	Past		Presently	Past	
____	____	High blood pressure	____	____	Menstrual difficulties
____	____	Low blood pressure	____	____	Prostate trouble
____	____	Strokes (CVA)	____	____	Sexual function difficulties
____	____	Dizziness	____	____	Rheumatoid arthritis
____	____	Ringing in the ears	____	____	Diabetes
____	____	Sinus trouble			
____	____	Headaches			
____	____	Seizures			
____	____	Multiple sclerosis			
____	____	Epilepsy			
____	____	Tuberculosis			
____	____	Thyroid trouble			
____	____	Allergies			
____	____	Shortness of breath			
____	____	Asthma			
____	____	Indigestion			
____	____	Ulcers			
____	____	Constipation			
____	____	Diarrhea			
____	____	Sudden unexpected weight loss			
____	____	Osteoporosis			
____	____	Difficulty releasing urine			
____	____	Difficulty holding urine			
____	____	Mental illness describe_____			
____	____	Cancer of what_____when_____			
____	____	Heart Disease describe_____when_____			

Do you have any of the following life style habits?

No	Yes	
____	____	Drink alcohol_____drinks per week
____	____	Smoke Tobacco _____packs per week
____	____	Use recreational/illegal drugs_____type
____	____	Drink caffeinated drinks _____per day
____	____	Exercise _____Times per week

what type_____

_____

_____

Patient name _____ ***Date*** _____ _____Reviewed

Scott Lembke, D.C. 11015 NE 4th Plain Suite B Vancouver, WA 98662 (360) 892-0451 2/17/05

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Lembke Chiropractic Clinic

Address: 11015 NE 4th Plain Rd Ste B, Vancouver, WA 98662

Phone: (360) 892-0451

Website: https://www.vancouverwashingtonchiropractor.com/

Hours

Monday	8:00 AM - 6:00 PM
Tuesday	8:00 AM - 12:00 PM
Wednesday	8:00 AM - 6:00 PM
Thursday	8:00 AM - 12:00 PM
Friday	8:00 AM - 6:00 PM