

# Welcome to Imagine Chiropractic

Dr. James M. Stites

12050 SE Holgate Blvd • Portland Or • 97266 • 503-760-8648

## Confidential Patient Data

### PATIENT INFORMATION

Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

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

Home Phone(\_\_\_\_) \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Name of Spouse, Partner or Nearest Relative \_\_\_\_\_

Phone \_\_\_\_\_

Your Occupation \_\_\_\_\_ Your Employer \_\_\_\_\_

Referred to this Office by:  Friend/Family Member – Name \_\_\_\_\_

Yellow Pages  Mail  Office Location  Other \_\_\_\_\_

Payment for Services will be by:  Self  Health Insurance  Automobile Insurance

Worker's Compensation  Medicare  Other

### INSURANCE INFORMATION (Copy of insurance card or fill out the following)

Name of Insurance Co. \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insureds Name \_\_\_\_\_ Relationship \_\_\_\_\_ Insureds ID/SS# \_\_\_\_\_

Group/Policy Name \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Are you covered by more than one insurance company?  Yes  No Name \_\_\_\_\_

### MEDICAL/FAMILY HISTORY S=Self M=Mother F=Father

(Please indicate which conditions have been experienced by the above by marking the appropriate boxes).

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**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS**

Please Rate Your Symptoms  
(1-10, with 1 being the least serious)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT  
WHEN AND HOW OCCURRED? \_\_\_\_\_

SYMPTOMS DEVELOPED FROM: JOB RELATED INJURY AUTO ACCIDENT ILLNESS UNKNOWN CAUSE  
GRADUAL ONSET SUDDEN ONSET DATE OCCURRED \_\_\_\_\_

SYMPTOMS HAVE PERSISTED FOR # \_\_\_\_\_ HOUR(S) \_\_\_\_\_ DAY(S) \_\_\_\_\_ WEEK(S) \_\_\_\_\_ MONTH(S) \_\_\_\_\_ YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? \_\_\_\_\_

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER HAD CHIROPRACTIC CARE? NO YES DOCTORS NAME \_\_\_\_\_  
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND? \_\_\_\_\_

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

DATE OF LAST PHYSICAL \_\_\_\_\_ DATE OF LAST SPINAL X-RAY \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING
- TURNING HEAD TURNING IN BED LIFTING SNEEZING WALKING
- LYING DOWN STANDING DRIVING GETTING UP FROM A SEAT
- OTHER \_\_\_\_\_

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:**

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING
- WALKING APPLYING HEAT APPLYING COLD STRETCHING EXERCISE TAKING MEDICINE
- OTHER \_\_\_\_\_

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss / confusion
- constipation depression /weeping spells diarrhea dizziness face flushed
- fainting fatigue fever head seems too heavy headaches insomnia
- light bothers eyes loss of balance loss of smell loss of taste low resistance to colds
- muscle jerking numbness in fingers numbness in toes pins and needles in arms
- pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset
- other \_\_\_\_\_

I authorize the release of information necessary to file insurance claims and to assign my medical benefits to Dr. James M. Stites. I am ultimately responsible for all charges incurred at Imagine Chiropractic and that my insurance is being billed as a courtesy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_