Nordquist Family Chiropractic
9909 168th St. E. #102
Puyallup WA. 98373

PATIENT HISTORY

DATE_________________

NAME ____ E-mail: ____________________________

ADDRESS_____________________________CITY_____________STATE_____ZIP_________

PHONE (H)______________PHONE (W)______________SOCIAL SECURITY #____________

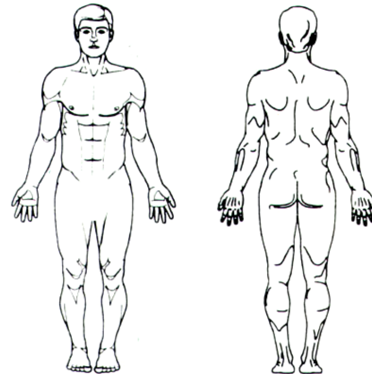
DATE OF BIRTH________________
EMPLOYER____________________________OCCUPATION____________________________

SPOUSE NAME_____________________

HOW WILL YOU BE PAYING FOR YOUR FIRST VISIT:
( )CASH ( ) CHECK ( )MASTERCARD ( ) VISA ( ) WORK OR PERSONAL INJURY

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?______________________

MAIN REASON FOR YOUR VISIT TODAY:
NECK PAIN HEADACHES MID-BACK
LOW BACK ARM SHOULDER LEG
HEALTH CHECK UP MAINTENANCE
OTHER________________________________



PAIN LEVEL: best 1 2 3 4 5 6 7 8 9 10 worst

(PLEASE MARK PAIN LOCATIONS ON THE DIAGRAM)

DATE OF ONSET:__________ GRADUAL SUDDEN PROGRESSIVE OVER TIME

HOW DID THIS INJURY OCCUR?____

WHAT MAKES YOU FEEL BETTER_____________________ ***WORSE?***________________________

HAVE YOU HAD THIS PROBLEM BEFORE?______***WHEN?***____________________________

WHAT MEDICATIONS ARE YOU TAKING?____

WHEN WAS YOUR LAST VISIT TO A CHIROPRACTOR?______________________________

DO YOU HAVE ANY OF THE FOLLOWING?

- ❑ HEADACHES
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DEPRESSION
- ❑ DIZZINESS
- ❑ MEMORY LOSS
- ❑ RINGING IN THE EARS
- ❑ DIGESTIVE PROBLEMS
- ❑ LIGHT SENSITIVITY
- ❑ STRESS OR ANXIETY
- ❑ NUMB HANDS OR FEET
- ❑ COLD HANDS OR FEET
- ❑ SHORTNESS OF BREATH
- ❑ DIFFICULTY SLEEPING
- ❑ LOSS OF SMELL OR TASTE

SIGNATURE____

(PLEASE LET THE STAFF COPY YOUR INSURANCE CARDS)