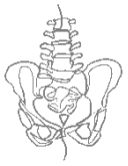
Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Dr. Betsy Burgos Diaz



Women's Health Chiropractic Intake form

Welcome to our office!! The following information is confidential. It will be used to complete your history and understand your condition, so please be as accurate as possible while completing this form. If you have any questions about this form, please ask at the front desk.

PATIENT INFORMATION Date ____/____/____

Patient Name _____
LAST FIRST MI

Address _____

City _____ State _____ Zip _____

Email _____

Cell Phone (_____)_____ Work Phone (_____)_____

Home Phone (_____)_____ Best time to reach you _____

Date of birth _____/_____/_____ Age _____ Sex ☐Male ☐Female

☐ Married ☐ Single ☐ Dating ☐Divorced ☐ Widowed

Occupation _____ Employer/School _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Primary Phone (_____)_____ Secondary Phone (_____)_____

REFERRAL INFORMATION

How did you hear about us? ☐ Facebook ☐ Family/Friend (Whom may we thank for referring you? _____)

☐ Internet Search ☐Primary Physician ☐ Staff ☐ Other _____

Can we send them a thank you note for referring you to us? ☐ Yes ☐ No

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PATIENT CONDITION

Current Health Concern: _____ When did this condition start? _____/_____/_____

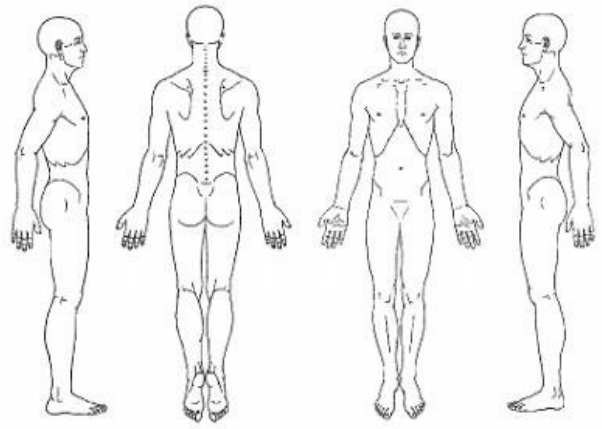
Rate your pain on a severity scale from 1 (least) to 10 (severe) _____

Mark an X on the picture where you have symptoms.

Describe your symptoms ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Stabbing ☐ Swelling
☐ Numbness ☐ Tingling ☐ Stiffness ☐ Other _____

How often do you have this pain? ☐ Constant ☐ Frequently ☐ Intermittent ☐ Occasionally

Does this condition interfere with: ☐ Work ☐ Family ☐ Sleep ☐ Daily Activities
☐ Sitting ☐ Standing ☐Walking ☐ Bending ☐ Lying down



Have you experienced this problem before? ☐ No ☐ Yes

Please Explain _____

Have you sought treatment for this condition before? ☐ No ☐ Yes

Please Explain _____

What are your goals during and after treatment?

1._____ 2._____

3._____ 4._____

PREVIOUS TREATMENT

Family Medical Doctor:_____ Date of last visit_____/_____/_____

Previous Chiropractic Care ☐ No ☐ Yes Name:_____ Date of last visit_____/_____/_____

What treatment have you already received for you condition? ☐ Acupuncture ☐ Chiropractic ☐ Massage
☐ Medications ☐ Physical Therapy ☐ Surgery ☐ None ☐ Other _____

Previous Diagnosis _____ Last X-Rays Taken _____/_____/_____

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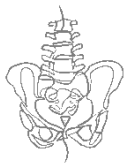

PREVIOUS INJURIES

Please describe any injuries or surgeries (e.g., slips/falls, head injuries, broken bones, dislocation, surgeries, auto accidents)

_____

_____

_____

HEALTH HISTORY

Please mark any of the following conditions that you have been diagnosed with or experience

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies (List: _____)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast Lump (s)
- ☐ Balance problems*
- ☐ Blood pressure – High - Low
- ☐ Fainting
- ☐ Cancer*
- ☐ Circulatory problems
- ☐ Cholesterol – High – Low
- ☐ Congenital Disease*
- ☐ Depression
- ☐ Diabetes – Type I – Type II
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Ear infection
- ☐ Body pain*
- ☐ Headaches
- ☐ Jaundice
- ☐ Pain with bowel movement
- ☐ UTI
- ☐ Liver problems*
- ☐ Polycystic Ovary Syndrome (POS)
- ☐ Dizziness
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Prostate problems
- ☐ Pelvic inflammatory Disease
- ☐ Fractures
- ☐ Fatigue
- ☐ Headaches
- ☐ Heartburn
- ☐ Heart problems*
- ☐ Hernia
- ☐ Herniated Disc*
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Night sweats
- ☐ Hemorrhoids
- ☐ Fibroids
- ☐ Chronic yeast infection
- ☐ Hip pain
- ☐ Painful menstrual cycles
- ☐ Nausea
- ☐ Night Sweats
- ☐ Mood swings, irritability
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched nerve
- ☐ Pneumonia
- ☐ Ringing in the ears
- ☐ Seizures/convulsions
- ☐ Sleep problems
- ☐ Temperature intolerance*
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Thyroid problems*
- ☐ Tuberculosis
- ☐ Tumor (s)*
- ☐ Unexplained weight-loss
- ☐ Visual problems*
- ☐ Vomiting
- ☐ Vertigo/dizziness
- ☐ Sore throat
- ☐ Chest pain
- ☐ Hot flashes
- ☐ Numbness legs or arms*
- ☐ Scoliosis
- ☐ Increase PMS
- ☐ Changes in menstrual cycle

☐ OTHER(s)_____

*Explain_____

_____

_____

Are you taking any medications or drugs? ☐ Yes ☐ No

Please List_____

Are you taking any vitamins/supplements/herbs/minerals? ☐ Yes. ☐ No

Please List_____

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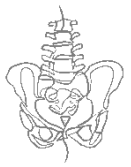

SOCIAL HISTORY

Mark all that applies

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor
- ☐ Other_____

HABITS
- ☐ Smoking Packs/day_____
- ☐ Alcohol Drinks/week_____
- ☐ Caffeine Cups/day_____
- ☐ High Stress Level
  Reason_____

FAMILY HISTORY (*any parents, siblings, grandparents, aunts & uncles have the following?)*

Mark all that applies

- ☐ Diabetes ☐ Heart Disease ☐ Hight blood pressure ☐ Stroke
- ☐ Breast Cancer ☐ Ovarian Cancer ☐ Colon Cancer ☐ High Cholesterol
- ☐ Blood Clots ☐ Mental Illness ☐ Osteoporosis ☐ Blood disorders
- ☐ Uterine cancer ☐ Cancer (other)_____
- ☐ Other_____

WOMEN'S HEALTH QUESTIONNAIRE

How often are your periods? _____ How long they last?_____

Menstrual cycle changes: ☐ Pre-menopause ☐ Menopause

Are you sexually active: ☐ Yes ☐ No If yes, what form of contraceptive are you using_____

Date of last PAP smear? _____ ☐ Normal. ☐ Abnormal

Have you ever had an abnormal PAP smear? ☐ No. ☐ Yes If yes, date _____

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
☐ Herpes. ☐ Gonorrhea. ☐ Chlamydia ☐ HIV ☐Genital Warts. ☐ Syphilis ☐ Pelvic inflammatory Disease
Other_____

Date of last mammogram_____ ☐ Normal ☐ Abnormal

Date of last bone density_____

How many times have you been pregnant? _____ # of vaginal deliveries_____ #of C-sections?_____

Reason for C-section?_____

Number of living children?_____ Number of miscarriages?_____ Number of stillbirths?_____

Number of abortions?_____

Did you experience any complications in birth? ☐ Pelvic Tear. ☐ Forceps ☐ Excessive bleeding ☐Abnormal heartrate

☐ Umbilical cord issues ☐ Failure to progress ☐ Malposition of baby ☐ Placenta issues

☐ Others_____

Any problems with postpartum depression?_____

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Office Policies

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. _____(initials)

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in. being charged the cost of the appointment_____(initials)

NOTICE OF PRIVACY PRACTICE *We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us or the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at (360) 352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. _____(initials)*

Informed Consent

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need, you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft tissue manipulation, nutritional recommendations, and exercise. Please list any preferences here_____

I have read the previous information regarding the risk of chiropractic care, and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been explained the treatment, the frequency of care, and alternatives to this care. All my questions have been answered to my satisfaction. I agree to this care plan, understanding any perceived risk(s) and alternatives to this care for the above minor patient. By signing, I give consent for examination, tests, and procedures for the above minor patient. _____(initials)

By signing, I have read and understood the Office Policies and Informed Consent:

Print Patient Name _____

Print Parent/Guardian Name _____

Parent/Guardian Signature_____ Date _____/_____/_____