

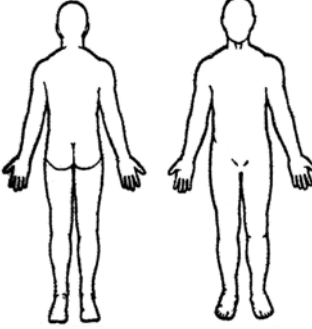
# / ROXBURY SPINE & WELLNESS CLINIC /

2656 SW Roxbury St.	Seattle WA 98126	
P.206.937.2000	866.937.8644	F. 206.937.4643
www.roxburyclinic.com	[contact@roxburyclinic.com](mailto:contact@roxburyclinic.com)	

LAST NAME _____	FIRST NAME _____ MIDDLE _____
ADDRESS _____	SS# _____ BIRTHDATE _____ AGE _____
CITY _____ STATE _____ ZIP _____	DL# _____ E-MAIL _____
OCCUPATION _____	SPOUSE _____ KIDS NAMES & AGES _____
EMPLOYER _____	SPOUSE'S OCCUPATION _____
PHONE # _____ WORK _____	EMPLOYER _____
CELL/PGR _____	HOW DID YOU HEAR ABOUT US? _____
INSURANCE CO. _____	POLICY # _____ CONTACT _____

What is your major complaint? _____	How intense is it on a scale of 1-10? (1-least, 10 worst) _____
When did this condition first develop? _____	How often does it bother you? 100%-75%-50%-25% of the time _____
Is this the first time? _____	What caused this condition? _____
What makes it worse? _____	Has the problem been getting worse, better, or staying the same? _____
What have you done to help yourself? _____	Other Doctors seen and recommendations: _____
Other complaints: _____	

Circle ALL areas of complaint on diagram.



How does it feel?

Sharp

Dull

Stiffness

Aching

Tingling

Numbness

Burning

Constant

Comes & Goes

Other

Please mark if you have you EVER had any of the following health issues:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Neck Problems              | <input type="checkbox"/> Sore Muscles      | <input type="checkbox"/> Allergies            |
| <input type="checkbox"/> Shoulder Problems          | <input type="checkbox"/> Walking Problems  | <input type="checkbox"/> Hay Fever            |
| <input type="checkbox"/> Arm Problems               | <input type="checkbox"/> Broken Bones      | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Numbness in Hands          | <input type="checkbox"/> Muscle Cramps     | <input type="checkbox"/> Eczema               |
| <input type="checkbox"/> Pain Between Shoulders     | <input type="checkbox"/> Weak Muscles      | <input type="checkbox"/> Shingles             |
| <input type="checkbox"/> Low Back Problems          | <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Poor Digestion       |
| <input type="checkbox"/> Leg Problems               | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Numbness in Legs           | <input type="checkbox"/> Forgetfulness     | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Loss of Feeling            | <input type="checkbox"/> Depression        | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Stiff Joints               | <input type="checkbox"/> Vision Problems   | <input type="checkbox"/> Kidney Infection     |
| <input type="checkbox"/> Painful Joints             | <input type="checkbox"/> Ear Pain/Noises   | <input type="checkbox"/> Menstrual Cramps     |
| <input type="checkbox"/> Restricts Daily Activities | <input type="checkbox"/> Ear Infections    | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Restricts Exercise         | <input type="checkbox"/> Hearing Loss      | <input type="checkbox"/> Blood Pressure Hi/Lo |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Tiredness/Fatigue | <input type="checkbox"/> Frequent Colds       |

This is a new / old condition. I have / haven't had care for it before. From birth to present, please list by date and describe:

If previous care, what was done? _____	Car Accidents _____
Name of Doctors: _____	_____
Have you ever had surgery or been hospitalized? Y / N	_____
List surgeries: _____	Falls/injuries (including Sports) _____
Have you EVER had chiropractic care before? Y / N	_____
Name of Doctor _____ Was it a good experience? Y / N	_____
Last time you had spinal x-rays or other x-rays: _____	Other _____
Medications you now take: _____	_____

*Feel free to fax this form in when completed*