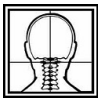


West Seattle Neighborhood Chiropractic
2140 California Avenue SW
Seattle, WA 98116
(206) 659-0771

PATIENT INFORMATION

Patient information contained within this form is considered *strictly confidential*.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Last Name _____ First _____

Middle _____ Nick Name _____ SS# _____-_____-_____

Street Address _____

City _____ State _____ Zip _____

1st Phone # _____ □ Home □ Mobile □ Work

2nd Phone # _____ □ Home □ Mobile □ Work

Email _____ DOB _____

Sex: □ Female □ Male □ _____

Marital Status: □ Single □ Married □ Partner □ Divorced □ Widowed □ Legally Separated

Employment: □ Employed □ Self-Employed □ Not Employed □ Retired □ Active Military

□ Full-Time Student □ Part-Time Student

Occupation _____

Employer _____ Preferred Language _____

How did you hear about Dr. Carolyn Fancher? _____

Have you seen anyone else for this condition? Who? _____

_____

Emergency Contact _____ Relationship_____

Contact Phone # _____ □ Home □ Mobile □ Work

If under 18, responsible party _____

Contact Phone # _____ □ Home □ Mobile □ Work

Give a brief detailed description of any health care concerns you are currently experiencing:

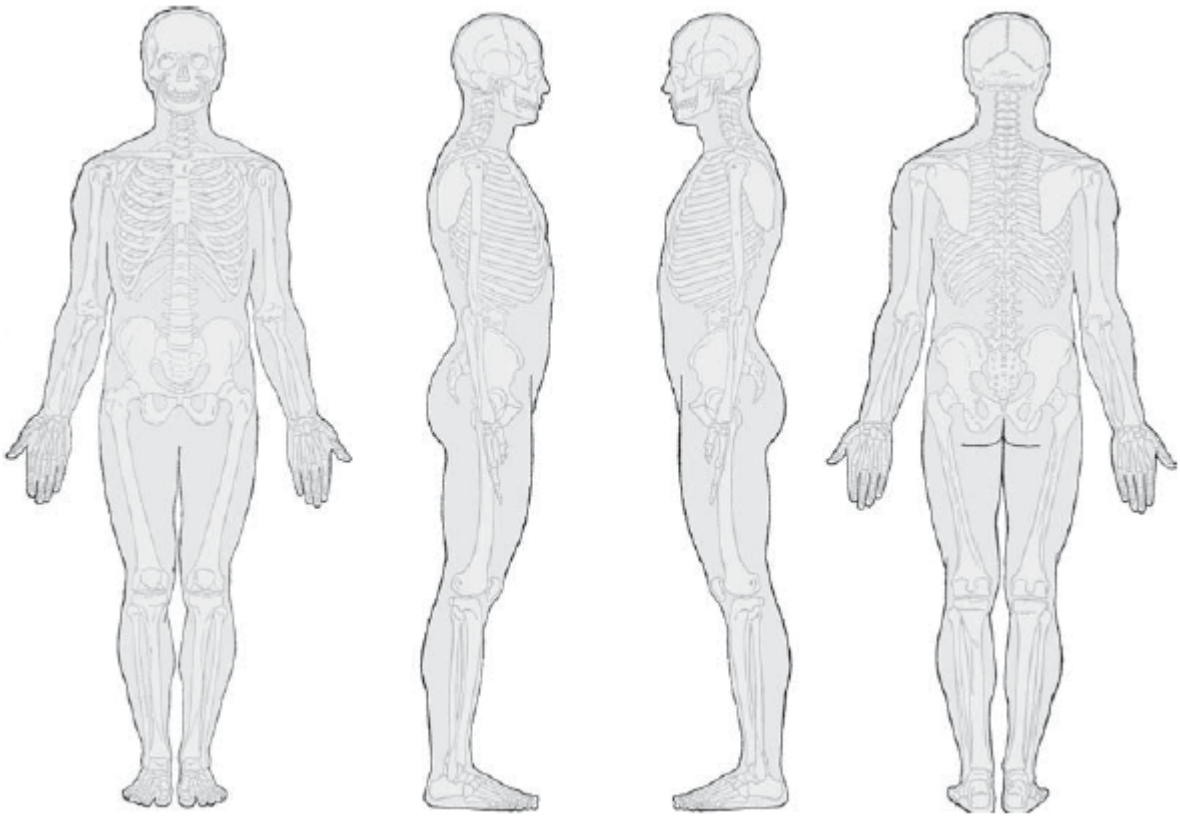
_____
_____
_____
_____

How long have you had this condition? _____ Is it getting worse? □ Yes □ No

Does it bother you (check appropriate box): □ work □ sleep □ other _____

What seemed to be the initial cause? _____

Front *Please mark area(s) of concern on the figures below* **Back**



Do you have any other health issues or concerns that our staff should be made aware of?

_____
_____
_____
_____

_____ _____

Signature Date

*PLEASE NOTE: If this is related to an Accident, please also complete the ACCIDENT REPORT form listed on the website.