CHIROPRACTIC PAIN RELIEF CLINIC, P.S.
DR. MILAN STOJAKOVIC, DC
1207 13TH STREET, SUITE G, SNOHOMISH, WA 98290

Patient Name: ____ Birth date: ________________ Sex: M F

Address: ____ City: ______________ State: _____ Zip: _________

Telephone: ____________ Cell: ____________ Work: _______________ E-mail: _________________________________

Appointment reminder day before: call to home ☐, call to cell ☐, text to cell ☐, e-mail ☐

Health Plan: _____________________________ Subscriber ID: _________________________ Group#: ________________

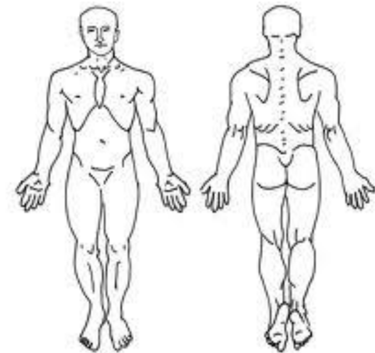
Primary Care Physician Name: ____Telephone: ___________________________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other: ____



Was this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem began: ________________

Current Complaint (how do you feel today)										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Pain									**Unbearable Pain**	

How often are your symptoms present?

(Intermittent) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

HAVE YOU HAD ANY SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ **NO** ☐ **YES**

Date(s) taken: _____________________________ What areas were taken? _______________________________________

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Please check all of the following that apply to you:

- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (date) ___________________________
- ☐ Corticosteroid Use (cortisone, prednisone, etc)
- ☐ Taking Birth Control Pills
- ☐ Dizziness/Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (explain) ___________________
  ____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Other Health Problems (explain)___________
  ____
  ____
- ☐ Prostrate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # weeks ________
- ☐ Abnormal Weight Gain Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances
- ☐ Surgeries__________________________
  ____
  ____
- ☐ Medications: _______________________
  ____
  ____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

By signing below I authorize the release of any medical or other information necessary to process my medical claim, and payment of medical benefits directly to Chiropractic Pain Relief Clinic, P.S.
PATIENT SIGNATURE (Parent or Guardian): ____Date: _____________

Consent to Treat a Minor Child

I here by authorize the authorize the doctors at Chiropractic Pain Relief Clinic, P.S. and whomever they designate as their assistants to administer treatment as they deem necessary to my minor child.
PARENT OR GUARDIAN SIGNATURE: ____ Date: ____________

Dr.'s Notes: