THE HEALING CENTER

4011 Arctic Blvd., Suite 203
Anchorage, AK 99503
Phone (907) 561-7041 Fax (907) 561-2349

FULL LEGAL NAME _____ **HOME PHONE** _____

MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____ **CELL PHONE** _____

EMAIL ADDRESS_____ **SOCIAL SECURITY NUMBER** _____

AGE _____ **SEX: M F BIRTH DATE** _____/_____/_____ **MARITAL: M S D W HOW MANY CHILDREN?** _____

OCCUPATION _____ **EMPLOYER** _____

EMPLOYER'S ADDRESS _____ **OFFICE PHONE** _____

NAME OF SPOUSE OR PARENT (please circle) _____ **OCCUPATION** _____

EMPLOYER OF SPOUSE OR PARENT _____ **OFFICE PHONE** _____

CONTACT IN CASE OF EMERGENCY _____ _____ **PHONE** _____

REFERRED TO OUR CLINIC BY _____

YOUR MAJOR COMPLAINT(S) TODAY / PURPOSE OF THIS APPOINTMENT: _____

PAIN LEVEL: on a scale of 1(mild) -10 (severe) _____ **DATE SYMPTOMS BEGAN:** _____
(If complaints are due to a work injury, motor vehicle accident or personal injury, please ask receptionist for additional paperwork.

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

DIAGNOSIS: _____ **TREATMENT** _____

LENGTH OF CARE _____ **RESULTS** _____

HAVE YOU BEEN TREATED FOR ANY OTHER CONDITION BY A MEDICAL PHYSICIAN OR CHIROPRACTOR WITHIN THE LAST YEAR? _____

DESCRIBE _____

DATE OF LAST PHYSICAL EXAMINATION _____

IF APPLICABLE, HAVE YOU EVER HAD A PROFESSIONAL MASSAGE/ACUPUNCTURE/OR OTHER BODYWORK?: _____

PLEASE COMPLETE THE FOLLOWING HEALTH HISTORY:

FRACTURES OR BREAKS: (which bones and dates?) _____

SURGERY: (type and date?) _____

_____

MAJOR ACCIDENTS/INJURIES: (what happened and when?) _____

CURRENT DRUGS/MEDICATIONS: _____

UNUSUAL DISEASES OR CONDITIONS: (name of and when diagnosed?) _____

PLEASE LIST ANY KNOWN ALLERGIES: _____

Please circle any of the following symptoms so that we may have a better understanding of your TOTAL health profile:

Headaches	Chest Pains	Depression	Loss of Smell	Excessive Coughing	Frequent Nose Bleeds
Neck Pain	Dizziness	Light Bothers Eyes	Loss of Taste	Swallowing Difficulty	Pressure Feeling in Head/Neck
Neck & Back Stiff	"Heavy" Head	Loss of Memory	Diarrhea	Burning Upon Urination	Spots in Front of Eyes
Sleeping Problems	Pins/Needles in Arms	Ears Ring	Feet Cold	Blood in Urine or Stool	Heart Palpitations
Back Pain	Pins/Needles in Legs	Face Flushed	Hands Cold	Shortness of Breath	Cramps
Nervousness	Numbness in Fingers	Buzzing in Ears	Constipation	Stomach Upset/Gas/Vomiting	Hot/Cold Flashes
Tension	Numbness in Toes	Loss of Balance	Cold Sweats	Loss of Bladder Control	Female Problems
Irritability	Fatigue/Tiredness	Fainting	Fever	Swelling Anywhere	Pregnant

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize The Healing Center to prepare and release any medical information necessary to process this claim either to my insurance company or attorney. Furthermore, I authorize payment of medical benefits for any service rendered by The Healing Center be made directly to The Healing Center where assignment is accepted However, I understand that any balance due to The Healing Center for services rendered to me or my family, which includes any bank fees incurred due to bad debt, are ultimately my responsibility and agree to pay any remaining balance in full. I understand that any outstanding balance that is 90 days or more past due is subject to further collections proceedings. If The Healing Center has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due to The Healing Center for services rendered to me or my family

PATIENT'S SIGNATURE _____ **DATE:** _____

GUARDIAN'S SIGNATURE _____ **DATE:** _____