Dr. Brooke Coates
2627 N 21st St
Tacoma, WA 98406
253.756.9990

COATES
CHIROPRACTIC

Date: _____

First Name _____ Last Name _____
Prefer to go by _____ Birthdate _____
Marital Status M S D W Spouse/Parent Name
No. of Children _____
Address _____
City _____ State _____ Zip _____
Email _____ Cell phone _____

Occupation _____ Employed by _____
Work Address _____

How did you hear about us? _____

Have you had chiropractic care before? ____ If so, when? _____
Was it helpful? _____

Are you taking any medications/drugs, if so please list.

_____ _____
_____ _____
_____ _____

Have you had any surgery or major medical issues? If so, please list.
Type _____ When? _____
Type _____ When? _____
Type _____ When? _____

Does your insurance cover chiropractic care? _____
Is this injury or illness work related? _____ Have you reported it to your employer? _____
Is this injury or illness related to an auto accident? _____

Method of payment you plan to use for today's charges? _____

List your chief concerns in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

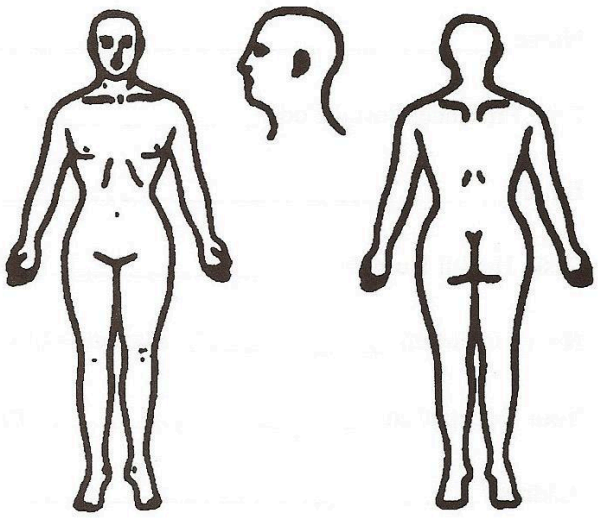
Is this condition interfering with:

☐ Work ☐ Sleep ☐ Daily routine ☐ Sports/Exercise ☐ Other

Are you now, or have you suffered from any of the following:

☐ Stroke
☐ Fatigue
☐ Migraine
☐ Nervousness
☐ Cancer
☐ Headache
☐ Shingles
☐ Arthritis
☐ Diabetes
☐ Backache
☐ Aneurysm
☐ Stiff Neck
☐ Numbness or pain in arms/legs/hands
☐ Heart Disease
☐ Heart Attack
☐ High Blood Pressure
☐ Dizziness
☐ Spinal Curvature
☐ Swollen Joints
☐ Polio
☐ Pregnant at this time
☐ Pain between shoulders
☐ Difficulty Sleeping
☐ Sinus or Allergies
☐ Osteoporosis

Please mark your areas of pain:



Please rate your pain, 1 absent to 10 extreme

1 ---------- 5 ---------- 10

Are symptoms:

☐ Getting worse ☐ Getting better ☐ Staying the same

AUTHORIZATION TO RELEASE INFORMATION:

To: Dr. Brooke Coates

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I herby release you of any consequence thereof.

Signature _____ Date _____

Witness _____ Date _____