Edmonds Health & Allergy Clinic

Dr. Ted Edwards - “Get & Stay Healthy. For Life!”

PI	WC	INS	MC	CA

Full Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Birthdate _____ _ Age: _____

eMail required: _____Height _____ Weight _____ Gender _____

☐ Married ☐ Single ☐ Other ☐ Employed ☐ Full Time Student ☐ Part Time Student

Tell me at least 3 things that have been bothering you lately: _____

_____

_____

From 1-10 - How bad is each symptom? _____

_____

How often are you experience your symptoms: ☐ Seldom ☐ Occasionally ☐ Comes & Goes ☐ Frequently ☐ It’s Constant

What makes you - feel better?

What makes you - feel worse?

Where do you have pain? stiffness? aches” numbness? or tingling?

☐ Head ☐ Jaw ☐ Migraines
☐ Neck ☐ w/Headaches ☐ +Top Shoulders
☐ Upper Back T1-5 ☐ Ribs front/back
☐ Mid Back T5-12 ☐ Sternum
☐ Lower back L 1-5
☐ Pelvis ☐ Sciatica ☐ Coccyx
☐ Shoulders ☐ Elbows ☐ Arms
☐ Wrist-Carpal Tunnel ☐ Hands
☐ Hip Joint ☐ Legs ☐ Knees
☐ Ankles ☐ Feet ☐ Toes

Please check any of the following the applies to you

☐ Tired, fatigued during the day
☐ Stressed by career, relationships
☐ Worried, anxious, moody
☐ Told I have a Thyroid Problem
☐ Crave sugar or carbohydrates
☐ Like foods made with wheat or corn
☐ Cancer runs in the family
☐ I’ve taken Antibiotics ___ times
☐ I have Belly Fat ☐ Brain Fog
☐ Overweight ☐ Underweight
☐ Disturbed sleep / Insomnia
☐ Coffee at night keeps me awake
☐ Family heart disease, diabetes
☐ Have or had Allergies, Asthma
☐ Stomach, indigestion problems
☐ Candida / Yeast Overgrowth
☐ Muscle/Joint pain ☐ Fibromyalgia
☐ Depression, Alzheimer’s in Family

What drugs or supplements are you taking? What are you taking them for?

_____

_____

Surgeries? Hospitalizations?_____

ARE YOUR PROBLEMS ☐ The result of an auto or other accident ☐ The result of an on-the-job injury?

Authorization for Examination and Treatment. Informed Consent. Privacy Acknowledgement

I hereby authorize Dr. Ted Edwards to examine and treat my symptoms and complaints using spinal manipulative therapy and ancillary physical therapy procedures. I authorize Dr. Ted Edwards to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to requesting third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Ted Edwards any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. By my signature I acknowledge receipt of the clinics Notice of Privacy Practices. Further I understand that while rare, complications may include an adverse reaction to the treatment or therapy provided. Due to the benefits of Dr. Edwards treatment I have freely decided to receive treatment and herby give my full consent to said treatment. I intend this consent to apply to all my present and future health care at Edmonds Health & Allergy Clinic.

_____ _____

Signature of Patient or Parent Today’s Date.

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