

Northgate Chiropractic

11065 5th Avenue NE Suite E, Seattle, WA 98125 · (206) 367-2224 · northgatechiro.com

Confidential Patient Information

Complete on screen or print clearly · Optional fields may be skipped unless needed for billing

Account # (office use) Today's date

PATIENT INFORMATION

Legal last name Legal first name Middle

Preferred name Pronouns (optional) Date of birth

Gender identity (optional — respectful care only; never used to deny services)

Woman

Man

Non-binary

Prefer not to say

Self-describe Title (Mx/Mr/Ms/Dr...)

Sex assigned at birth (optional — skip if not needed)

Female

Male

Intersex

Prefer not to say

Relationship / household (optional)

Married

Partnered / domestic partner

Single

Widowed

Divorced

Prefer not to say

Street address City State ZIP

Mobile phone Home phone Email

SSN (optional — only if required for insurance billing) Occupation

Employer Work phone

Emergency contact

Name Relationship Phone

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT)

Name Relationship Phone

Address City State ZIP

INSURANCE

Please provide insurance cards and any required claim forms to staff. Health information is handled per the clinic's privacy practices (northgatechiro.com/privacy), including Washington MHMDA where applicable.

Primary insurance company Member / ID #

Secondary insurance (if any) Member / ID #

I will provide insurance cards to staff

Yes, today

Later / will send

SYMPTOMS

1 What is your number one problem or the one area of greatest pain?

2 Rate this pain (0 = none, 10 = worst). Check one, or two for a range:

0 1 2 3 4 5 6 7 8 9 10

3 When did this problem / pain start?

3b Onset: Gradual Sudden Progressive

4 What do you think caused this problem?

5. How often do you experience the pain?

1–2 hours per day

Most of the day

About half the day

The pain never goes away

6. How does the pain affect your daily activities?

Does not affect activities

Stopped some activities

Changed how I do things

Unable to perform daily activities

7 What increases your pain?

8 What decreases your pain?

9 Have you ever experienced this problem before? Yes No

9b When?

10. Other current complaints — describe each, then check a 0–10 rating:

a.		0	1	2	3	4	5	6	7	8	9	10
b.		0	1	2	3	4	5	6	7	8	9	10
c.		0	1	2	3	4	5	6	7	8	9	10
d.		0	1	2	3	4	5	6	7	8	9	10

INJURY AND MEDICAL HISTORY

11 Have you ever been involved in an automobile accident? Yes No

11a When?

11b Were you injured? Yes No

11c Explain

12 Have you ever been injured at work? Yes No

12a When?

12b Explain

13 List all medications you currently take (prescribed and over-the-counter)

14 List all surgeries (with approximate dates)

HEALTH HISTORY CHECKLIST

Mark P = past condition, C = currently experiencing. Answer only as comfortable. This supports clinical safety — not a diagnosis.

P C Condition

Heart attack / heart disease

Arthritis

Diabetes

Fainting spells

Difficulty with urination

Difficulty with bowel movements

Cancer

HIV

Diverticulosis

Dizziness

Chest pain

Constipation

General fatigue

Nausea

Soreness in joints

Ears ringing (tinnitus)

P C Condition

Stroke / TIA

Gallbladder trouble

Glaucoma

Kidney stones / disease

Bloody stools

Anemia

Asthma

Ulcers

Menstrual cramping / pelvic pain

Loss of memory

Shortness of breath

Diarrhea

Sudden weight loss

Muscle cramping

Loss of hearing

Headache

Migraine	Epilepsy / seizures
Gout	Tuberculosis
STI (note details if needed)	Knee / hip replacement
Broken bones	Sprained ankle — right
Sprained ankle — left	Osteoporosis / low bone density
Blood clots / DVT	Pregnant or possible pregnancy

Notes / specify (broken bones, STI, etc.)

GENERAL ACTIVITIES

Check all that apply to your usual routine.

Sleep on waterbed	Read in bed	Fall asleep in recliner / couch
Sleep on stomach	Needlework / crafts	Two or more pillows
Sewing	Lift weights / machines	Video games
Exercise regularly	Jog / run	Computer / desk work
Swim	Gym / cardio equipment	Watch television

Exercise × / week

Jog × / week

Screen / game hrs per day

Anything else you would like the doctor to know?

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that the information on this form is true and complete to the best of my knowledge. I understand that incorrect information can be dangerous to my health and may affect insurance benefits. I authorize Northgate Chiropractic and its providers to release information reasonably necessary for treatment, payment, and health care operations to third-party payers and other health practitioners involved in my care. I assign and authorize payment of insurance benefits directly to Northgate Chiropractic for services rendered. I understand my insurer may pay less than the full charges and that I remain responsible for balances not paid by insurance, except as limited by law or written agreement. Health information I provide may be consumer health data under Washington's My Health My Data Act (MHMDA) and is handled per the clinic's privacy practices (northgatechiro.com/privacy).

I have read and agree to the authorization above

Patient / guardian printed name

Date

Signature (type full legal name if completing electronically)

Parent or guardian signature required if the patient is a minor.

Form version 2026-07 fillable · Original archived at public/pdfs/archive/northgate-chiropractic-newpatient-original.pdf · © Northgate Chiropractic — clinic use

Body Diagram

Mark pain on the figures using the symbols shown · Print & pen, or use PDF draw/annotate tools

Account #

Last name

First name

XXX

Sharp Pain

OOO

Dull Ache

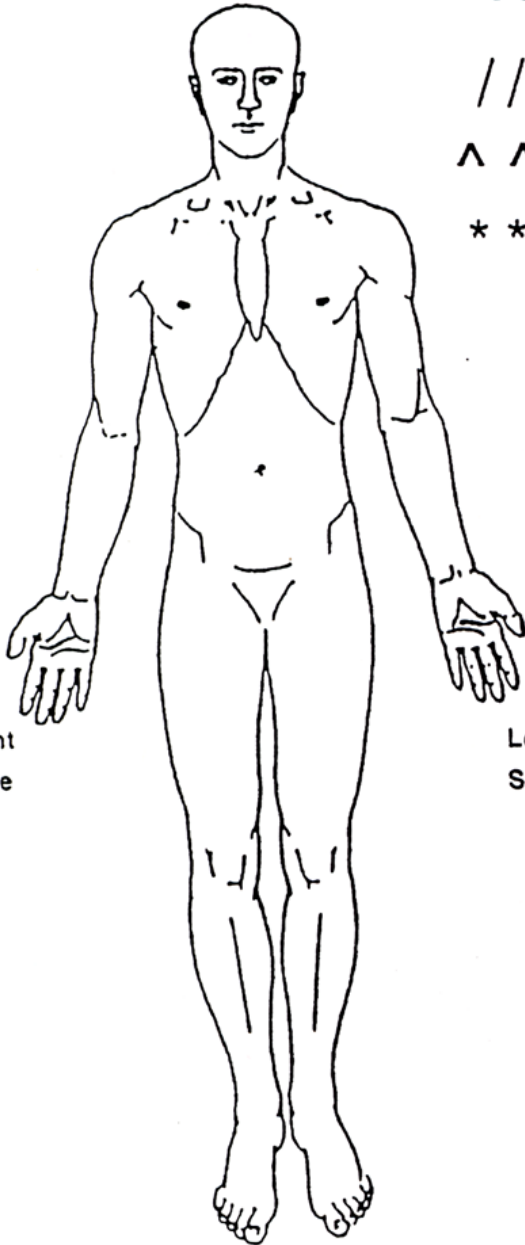
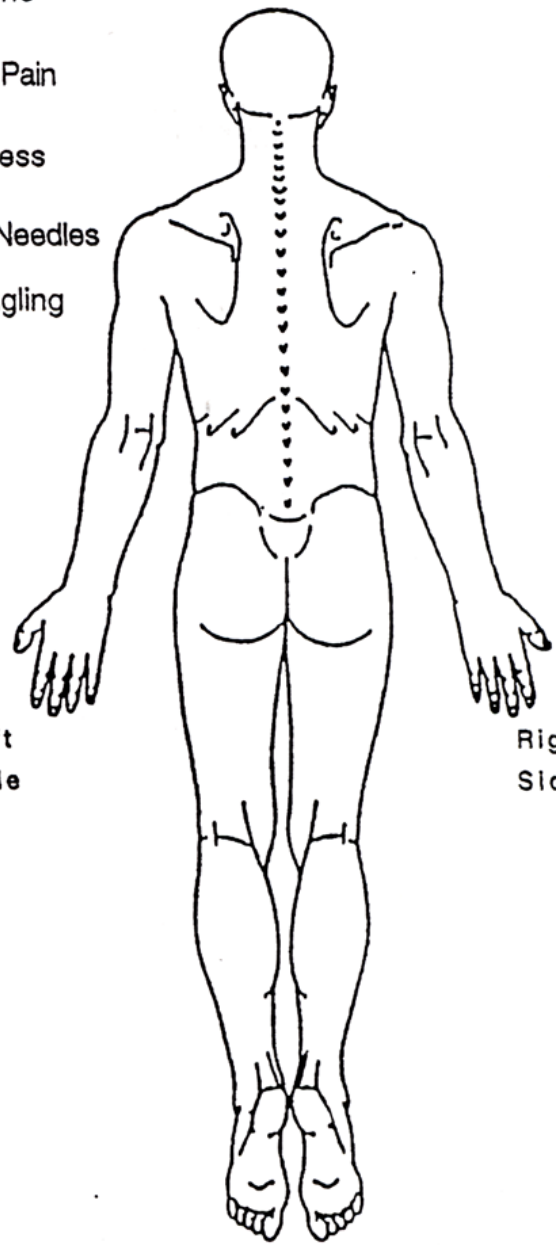
///

Burning Pain

^ ^ ^

Numbness

* * *

Pins & Needles
or TinglingRight
SideLeft
SideLeft
SideRight
Side

Optional written locations (if you cannot mark the diagram):

Patient / guardian signature

Date

Parent/guardian signature if patient is a minor. Anatomy figures preserved from original clinic form (not redrawn).