ARCHER FAMILY WELLNESS CLINIC
DONNA MARIA ARCHER, DC

PATIENT INFORMATION Today's Date:

Name: ____________________ DOB: ____________________ Age:_____ M / F
Address: ____________________ Social Security#: ____________________
City ____________________ Occupation: ____________________
State / Zip: ____________________ Employer: ____________________
Spouse: ____________________ Empl. Address: ____________________
Spouse Emp. ____________________ Single___ Married___ Divorced___ Other___
Soc. Security #

PHONE NUMBERS

Home Phone: ____________________ Emergency Contact: ____________________
Work Phone: ____________________ Relationship: ____________________
Cell Phone: ____________________ Phone: ____________________
E-mail: ____________________ Medical Doctor: ____________________
____________________ Phone: ____________________

Whom may we thank for referring you (or how did you hear about our office)?

INSURANCE INFORMATION (We will be happy to bill your primary insurance; secondary is your responsibilty.)

Primary Insurance		Secondary Insurance	
Health Plan:		Health Plan:	
Subscriber Name:		Subscriber Name:	
Subscriber ID #:		Subscriber ID #:	
Group #:		Group #:	
Subscriber DOB:		**Subscriber DOB:**	

CERTIFICATION, ASSIGNMENT AND RELEASE

I cerrtify to the best of my knowledge, the above information is complete & accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered & I agree to notify my provider immediately whenever I have a change in my health condition or health plan coverage. I understand that my provider or a clinical peer employed by my health care plan may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my provider and / or my health care plan to contact my physician, if necessary.

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to my provider (listed above) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finaincially responsible for all charges whether or not paid by insurance. I hereby authorize my provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________ ____________________
Responsible Party Signature Date

ARCHER FAMILY WELLNESS CLINIC

DONNA MARIA ARCHER, DC

Patient's Name: Today's Date:

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Type: ___auto ___work ___home ___other

Date of Accident: ____________________ Accident State: __________

To whom have you made a report of your accident?

___ Auto Insurance ___ Employer ___ Worker Comp. ___ Other

Attorney Name (if applicable): Phone:

Patient Condition

What is your present complaints / concerns? Onset Date: Type of pain: (please circle)

sharp	dull	throbbing
aching	numbness	shooting
burning	tingling	cramps
stiffness	swelling	other

Frequency: Constant Frequent Intermittent Ocassional **Severity:** Mild Moderate Severe

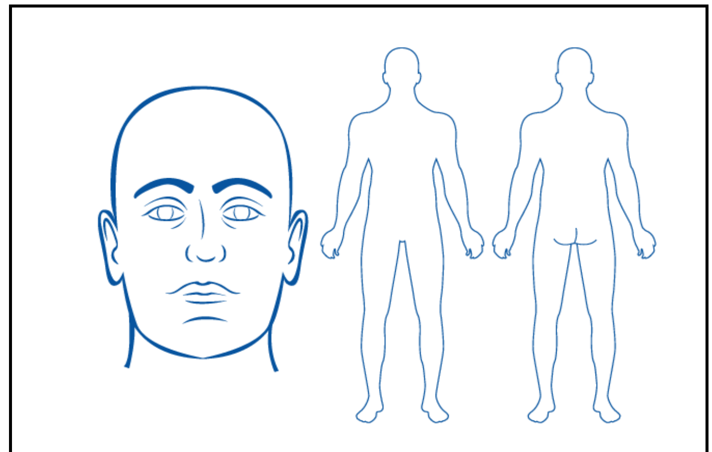
The problem is (please circle): getting worse getting better staying the same

Does it interfere with (please circle): work sleep daily routine recreation

Activities or movements that are painful to perform (please circle):

sitting standing walking bending lying down other: ____________

List any treatments or medications you have received for this condition and dates and how long.



Mark an X where you feel pain or discomfort

Have you received chiropractic care before? Y N

If yes, from whom?

How would you rate your previous care?

___Satisfactory ___Unsatisfactory

Have you had spinal x-rays performed within the last year? Y N

When? _________________ Where:_________________

On a scale of zero to 10, I rate my discomfort at:

0 No Pain (Mark an X at appropriate spot on line above) 10 Not Imaginable

Would you like to be placed on our clinic prayer list? Y N

Responsible Person's Signature Date

9330 NE Vancouver Mall Drive, Suite 203
VANCOUVER, WA 98662

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FAX: 360-859-3741