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 ☐ About half the day

☐ Most of 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	P	C	Condition
☐	☐	Heart attack / heart disease	☐	☐	Stroke / TIA
☐	☐	Arthritis	☐	☐	Gallbladder trouble
☐	☐	Diabetes	☐	☐	Glaucoma
☐	☐	Fainting spells	☐	☐	Kidney stones / disease
☐	☐	Difficulty with urination	☐	☐	Bloody stools
☐	☐	Difficulty with bowel movements	☐	☐	Anemia
☐	☐	Cancer	☐	☐	Asthma
☐	☐	HIV	☐	☐	Ulcers
☐	☐	Diverticulosis	☐	☐	Menstrual cramping / pelvic pain
☐	☐	Dizziness	☐	☐	Loss of memory
☐	☐	Chest pain	☐	☐	Shortness of breath
☐	☐	Constipation	☐	☐	Diarrhea
☐	☐	General fatigue	☐	☐	Sudden weight loss
☐	☐	Nausea	☐	☐	Muscle cramping
☐	☐	Soreness in joints	☐	☐	Loss of hearing
☐	☐	Ears ringing (tinnitus)	☐	☐	Headache

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

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

GENERAL ACTIVITIES

Check all that apply to your usual routine.

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

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

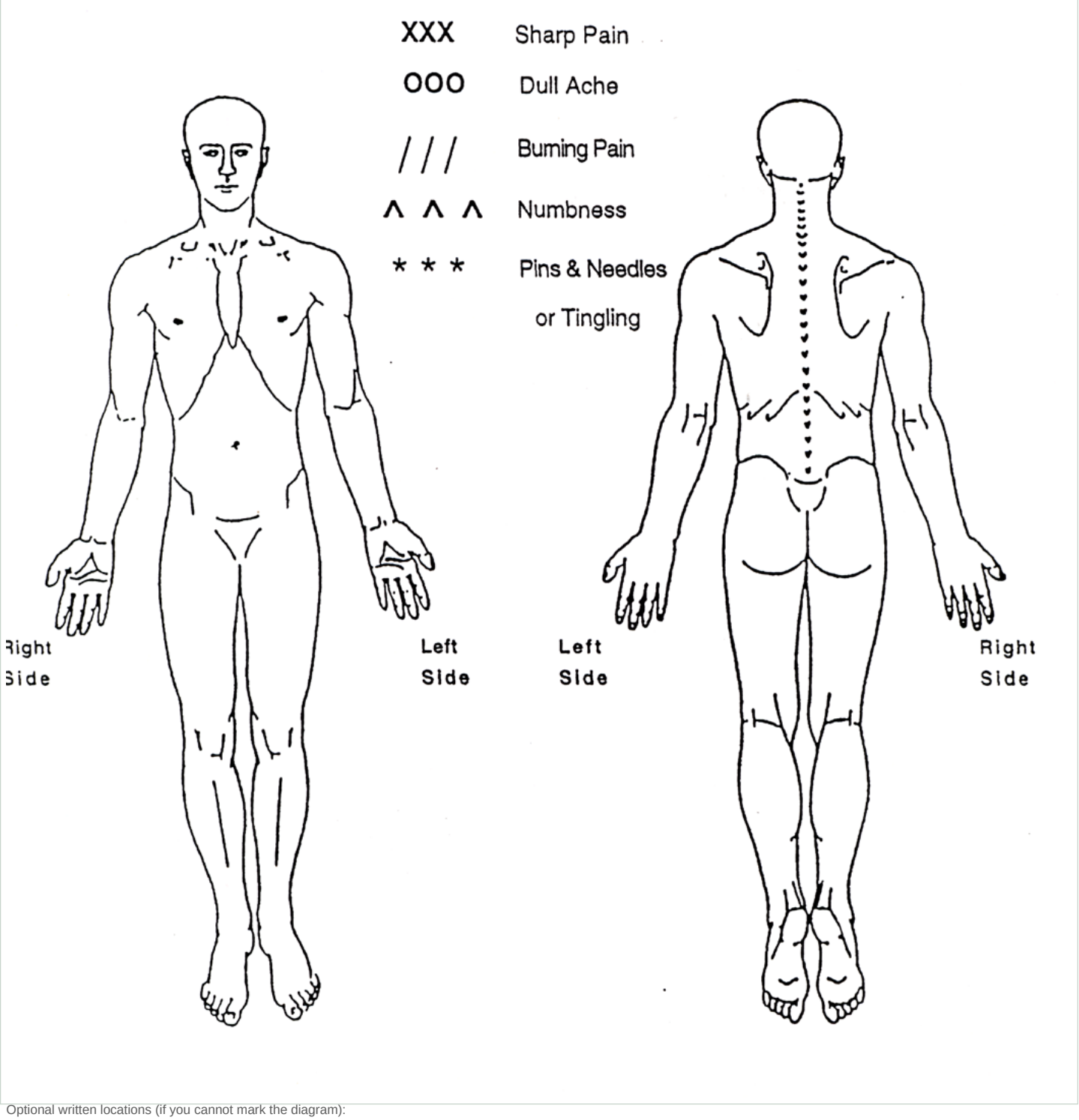
Signature (type full legal name if completing electronically)

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



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).