Smith Family Chiropractic

NEW PATIENT
CONFIDENTIAL HEALTH INFORMATION

Name (Last)_____ (First)_____ (Middle)_____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birth Date** _____ **Marital** S M D W **Sex** M F **SS #**_____ **Spouse's Name** _____

Cell # (_) _____ **Home #** (_)_____ **Spouse Cell #** (__)_____ **EMAIL ADDRESS**_____

Patient's Employer _____ **Job** _____

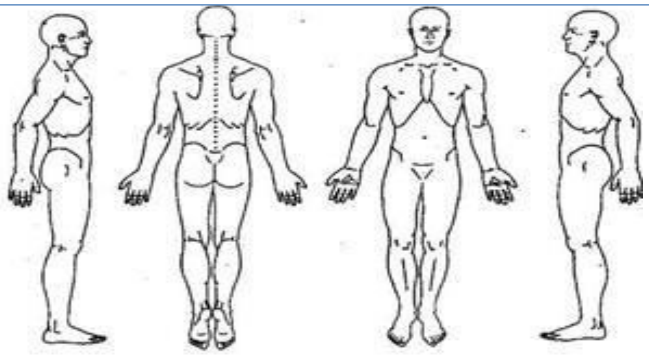
Address _____ **Work #** (___)_____

Insurance Co. _____ **Group#** _____ **ID #** _____

Name of Insured _____ **Birth Date** _____ **SS#** _____

Insured's Employer _____ **Work #** (___)_____

Relation to Insured _____ **Referred by** _____



Please outline and shade where you have pain or other symptoms

When did your symptoms start?_____

How did your symptoms begin?_____

1. PRIMARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
___ Constant (76-100%)
___ Recurring (51-75%)
___ Intermittent (26-50%)
___ Occasional (0-25%)

Describe Your Symptoms:
___ Sharp ___ Shooting
___ Dull ___ Burning
___ Numbness ___ Tingling

What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the : _

2. SECONDARY condition:

(Choose ONLY ONE)

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
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___ Sharp ___ Shooting
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What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing _ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine ____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Condition feels worse in the : _

3. ADDITIONAL conditions:

___ Head ___L ___R Shoulder
___ Neck ___L ___R Elbow
___ Upper Back ___L ___R Arm/Hand
___ Mid Back ___L ___R Hip
___ Lower Back ___L ___R Knee
___ Pelvis ___L ___R Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often? **(% of the day):**
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___ Sharp ___ Shooting
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What makes your symptoms worse?
___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?
___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine ____

Condition feels better in the :
___ Morning ___ Afternoon __ Evening

Have you seen another doctor for your CURRENT condition(s)?	___ No	___ Yes	When_____	
Have you had previous tests or studies for your CURRENT condition(s)?	___ No	___ Yes	When_____	
Have you had previous medications or care for your CURRENT condition(s)?	___ No	___ Yes	When_____	
Have you lost time from work due to this CURRENT problem?	___ No	___ Yes	When_____	
Have you had SIMILAR symptoms in the past?	___ No	___ Yes	When_____	
Have you had Chiropractic care before?	___ No	___ Yes	When_____	
To your knowledge, are you pregnant?	___ No	___ Yes		
Are you taking birth control medicines?	___ No	___ Yes		
Are you seeing an OB-GYN doctor regularly?	___ No	___ Yes	Name_____	

Your Past History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Grandparents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Parents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
M-for Mother	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
F-for Father	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Siblings' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems

Current Medications:	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Your Social History:	__ **Never Smoked**	__ **Former Smoker**	__ **Current Smoker**
	__ No Alcohol	__ Drink Alcohol	__ No Recreational Drugs
Allergies:	__ Sinus /	__ Food / Digestion	__ Skin
	__ Prescription Medicine (Names Allergic To)_____		
Surgeries/Hospitalized:	Type/area_____	Surgeon_____	When?_____
	Type/area_____	Surgeon_____	When?_____
	Type/area_____	Surgeon_____	When?_____

In general, my health is:	__	Excellent	__	Very Good	__	Good	__	Fair	__ Poor
Compared to a year ago, my health is:	__	Excellent	__	Very Good	__	Good	__	Fair	__ Poor
Decrease of social activities during the past 4 weeks:	__	Not at all	__	Slightly	__	Moderately	__	Quite a bit	__ Extremely

General:	__	Fatigue	__	Weakness	__	Fever / Chills	__	Weight Change	__ Night Sweats
Skin:	__	Pain	__	Rash	__	Redness	__	Itching	__ Eczema
Eyes:	__	Pain	__	Discharge	__	Infection	__	Vision Trouble	
Ears:	__	Pain	__	Discharge	__	Infection	__	Hearing Trouble	__ Ringing
Nose:	__	Pain	__	Bleeding	__	Infection	__	Absence of smell	__ Obstruction
Mouth/Throat:	__	Pain	__	Bleeding	__	Gum Disease	__	Abnormal Taste	__ Lesions
Heart:	__	Pain	__	Palpitations	__	Edema/ Swelling	__	Murmur	__ Fainting
Lungs:	__	Pain	__	Cough	__	Phlegm	__	Difficult breathing	__ Bloody Discharge
Gastrointestinal:	__	Pain	__	Nausea	__	Diarrhea	__	Constipation	__ Weight Change
Genitourinary:	__	Pain	__	Discharge	__	Blood in Urine	__	Incontinence	__ Frequent Urination
	__	Sterility	__	Impotence	__	Abnormal Bleeding	__	Amenorrhea	
Endocrine	__	Hair Loss	__	Thirsty	__	Tremors	__	Hot/cold intolerance	__ Sleep issues
Neurological:	__	Headaches	__	Seizures	__	Dizziness	__	Numbness	

Height:_____ft. _____in. **Weight**: _____lbs. **Blood Pressure**:_____/_____

APPLICATION FOR TREATMENT

Please check the type of care desired: ☐ **Temporary Relief** ☐ **Lasting Correction**

Are you interested in improving your overall health? ☐ **Yes** ☐ **No**

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me and charged to me are my responsibility to be paid to the doctor. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S _____ **DATE** _____

GUARDIAN'S _____ **DATE** _____