SMITH CHIROPRACTIC
A WELL ADJUSTED FAMILY

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Personal Information

Name First Middle Last Suffix

Address | Mailing Address ☐ Same

City State Zip | City State Zip

Phone Home Cell Work **Email** **Contact Preference** ☐ Home ☐ Cell ☐ Work ☐ Email

Birthdate (MM/DD/YYYY) **Social Security Number**

Gender ☐ Male ☐ Female ☐ Decline to answer

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Decline to answer

Height **Weight** **Primary Care Physician**

Insurance Carrier **Relationship to Policy Holder**

Primary Complaint

The primary reason for my visit today is _____

the result of ☐ Accident/Injury ☐ Auto ☐ Work ☐ Other _____

When did you first notice your current symptoms? _____

On a scale of 0 – 10, please rate your current pain. **0 1 2 3 4 5 6 7 8 9 10**
(0 = no pain, 5 = cannot be ignored for >30 min, 10 = unconscious from pain)

What have you done to relieve the symptoms?

☐ Prescription medication
☐ Over-the-counter medication
☐ Homeopathic remedies
☐ Chiropractic
☐ Ice
☐ Heat
☐ Massage
☐ Physical Therapy
☐ Acupuncture
☐ Surgery
☐ Other: _____

Secondary Complaint

The secondary reason for my visit today is _____

the result of ☐ Accident/Injury ☐ Auto ☐ Work ☐ Other _____

When did you first notice your current symptoms? _____

On a scale of 0 – 10, please rate your current pain. **0 1 2 3 4 5 6 7 8 9 10**
(0 = no pain, 5 = cannot be ignored for >30 min, 10 = unconscious from pain)

What have you done to relieve the symptoms?

☐ Prescription medication
☐ Over-the-counter medication
☐ Homeopathic remedies
☐ Chiropractic
☐ Ice
☐ Heat
☐ Massage
☐ Physical Therapy
☐ Acupuncture
☐ Surgery
☐ Other: _____

What else should the doctor know about your condition? _____

Daily Living How does this condition currently interfere with your life & ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No	Mild	Mod	Severe
Sitting	☐	☐	☐	☐	Grocery shopping	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐	Household chores	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Lifting objects	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Reaching overhead	☐	☐	☐	☐
Lying down	☐	☐	☐	☐	Showering/bathing	☐	☐	☐	☐
Bending over	☐	☐	☐	☐	Dressing myself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	Sex life	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐	Getting to sleep	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	Staying asleep	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	Concentrating	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐	Exercising	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐	Yard Work	☐	☐	☐	☐

Current Medical Conditions ex: diabetes, hypothyroidism, high blood pressure

Current Medications & Supplements

Review of Systems please mark all current and former conditions

Musculoskeletal	☐ Osteoporosis	☐ Arthritis	☐ Scoliosis	☐ TMJ	☐ Neck injury	☐ Back injury
☐ Shoulder injury	☐ Elbow/wrist injury	☐ Knee injury	☐ Hip injury	☐ Foot/ankle injury	☐ Poor posture	☐ None
Neurological	☐ Headache	☐ Dizziness	☐ Numbness	☐ Pins & needles	☐ Depression	☐ Anxiety ☐ None
Cardiovascular	☐ High blood pressure	☐ Low BP	☐ Poor circulation	☐ Heart disease	☐ Excessive bruising	☐ None
☐ Heart disease						
Respiratory	☐ Emphysema	☐ Asthma	☐ Apnea	☐ Pneumonia	☐ Shortness of breath	☐ None
Digestive	☐ Constipation	☐ Diarrhea	☐ Heartburn	☐ Ulcer	☐ Food sensitivities	☐ None
Sensory	☐ Chronic ear infection	☐ Ringing in ears	☐ Hearing loss	☐ Loss of smell	☐ Loss of taste	☐ None
Skin	☐ Psoriasis	☐ Skin cancer	☐ Eczema	☐ Rash	☐ Hair loss	☐ None
Endocrine	☐ Hypoglycemia	☐ Diabetes	☐ Thyroid issues	☐ Immune disorder	☐ Low energy	☐ None
Genitourinary	☐ Polycystic ovary syndrome	☐ Kidney stones	☐ Prostate issues	☐ Urinary tract infection	☐ Bedwetting	☐ None
Constitutional	☐ Sudden weight change	☐ Fatigue	☐ Fainting	☐ Weakness	☐ Poor appetite	☐ None

Social History

Alcohol Use	☐ None	☐ Daily	☐ Weekly	How much?	
Tobacco Use	☐ None	☐ Daily	☐ Weekly	How much?	
Caffeine Use	☐ None	☐ Daily	☐ Weekly	How much?	
Pain Reliever Use	☐ None	☐ Daily	☐ Weekly	How much?	
Exercise	☐ None	☐ Daily	☐ Weekly	How much?	

Family History

Cancer	☐ Self	☐ Parent	☐ Sibling	☐ Grandparent	☐ Aunt/Uncle	☐ Other
Diabetes	☐ Self	☐ Parent	☐ Sibling	☐ Grandparent	☐ Aunt/Uncle	☐ Other
High Blood Pressure	☐ Self	☐ Parent	☐ Sibling	☐ Grandparent	☐ Aunt/Uncle	☐ Other
Heart Disease	☐ Self	☐ Parent	☐ Sibling	☐ Grandparent	☐ Aunt/Uncle	☐ Other
Bone Disease	☐ Self	☐ Parent	☐ Sibling	☐ Grandparent	☐ Aunt/Uncle	☐ Other

HIPAA Release Form

Please list any individual you would like to have access to your medical information.

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

Acknowledgments

Please read each statement and initial your agreement.

_____ I may request a copy of the privacy policy and I understand it describes how my personal health information is protected and only released on my behalf when seeking reimbursement from involved third parties.

_____ I acknowledge that any insurance I have is an agreement between the carrier and me. I am responsible for the payment of any covered or non-covered services.

_____ I instruct the chiropractor to deliver the care that in his professional judgement can best help me in the restoration of my health. I accept that there are some risks to chiropractic treatment, including but not limited to increased symptoms of pain, strains, sprains, broken bones, and vertebral artery dissection.

_____ I realize that an x-ray examination may be hazardous to an unborn child. I certify that to the best of my knowledge I am not pregnant.

_____ As the parent/guardian of the patient named above, I authorize Smith Chiropractic Center, LLC to examine, diagnose, and treat my underage child/ward.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Signature (Patient or Parent/Guardian) **Date**