Smith Family Chiropractic

ABOUT THE PATIENT

Name:_____ **Date:**_____

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

Home Phone:_____ **Cell Phone:** _____ **Work Phone:** _____

Email Address:_____**(for sending exercises) Are you pregnant? Y ☐ N ☐ Due Date:**_____

Cellular Provider:_____ **Birth Date:**___/___/_____ **Age:**_____ **Male:**_____ **Female:**_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed # of Children:_____ **Ages:**_____

Occupation:_____ **Employer:**_____

Employer Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Spouse Name:_____ **Contact Number:**_____

Whom may we thank for referring you to our office?_____

Have you seen a Chiropractor before? ☐Yes ☐No Approximate Date of Last Visit_____

Reason for those visits?_____ **Doctor's Name**_____

REASON FOR THIS VISIT? If you are experiencing any pain (neck, mid back, low back, etc) or other health problem list them here.

1._____**How Long?**_____ **2.**_____**How Long?**_____

3._____**How Long?**_____ **4.**_____**How Long?**_____

If **job related**, have you reported this accident to your employer? **☐Yes ☐No ☐N/A**

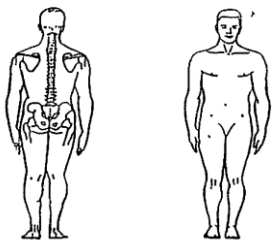
If related to a **car accident**, have you reported this injury to the insurance? **☐Yes ☐No ☐N/A**

YOUR HEALTH SUMMARY

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Neck/UB/MB/LB Pain
☐ Headaches/Migraines
☐ Dizziness
☐ Fever
☐ Sinus/Allergies
☐ Ear Infections
☐ Ringing/Buzzing in Ears
☐ Pain Behind Eyes/Blurred Vision
☐ Loss of Taste/Smell
☐ Fainting/Loss of Balance
☐ Shoulder Pain L/R
☐Nervousness
☐ Wrist Pain L/R
☐ Thyroid Problems
☐ Depression
☐ Mood Swings/Irritability
☐ Fatigue/Sleeping Problems
☐ Chest Pain/Shortness of Breath
☐ Cold Sweats/Hot Flashes
☐ Heart Palpitation/Murmur
☐Other:_____
☐ Asthma/Upper Resp. Infection
☐ Heart Burn/Indigestion
☐ Ulcers/Acid Reflux
☐ Stomach/Digestive Problems
☐ Excess Gas
☐ Cramping in Arms/Legs
☐ Sciatica L/R
☐ Hip Pain L/R
☐ Cold/Burning/Itchy Hands/Feet
☐ Pn, Numb, Ting, Wk to Arms/Legs
☐ Diarrhea/Constipation
☐ Freq. Urination/Urinary Infec.
☐ Cramping/Irregular Periods
☐ Difficulty Getting Pregnant/Impotence

Please indicate/mark your problem areas on the diagram below:



MEDICATIONS I NOW TAKE:

Please list any Medication/Supplements you are currently taking:_____

_____

PAST SURGERIES:

Please list any Surgeries you have had in the past: (type/year)_____

_____

HEALTH HABITS:

Do you smoke? ☐ Yes ☐ No _____packs/day. **Do you drink alcohol?** ☐ Yes ☐ No _____drinks/day.

Do you drink coffee? ☐ Yes ☐ No _____cups/day **Do you exercise regularly?** ☐ Yes ☐ No How Often?_____

Do you wear: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐ Other:_____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that……

♦Doctors of Chiropractic work with the nervous system? ☐ Yes ☐ No

♦The nervous system controls all bodily functions and systems? ☐ Yes ☐ No

♦Chiropractic is the largest natural healing profession in the world? ☐ Yes ☐ No

♦If Chiropractic care starts at birth; you can achieve a higher level of health throughout life? ☐ Yes ☐ No

ABOUT MY INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting 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.

Insurance Company_____ **Policy Holder Name**_____

ID #_____ **Employer**_____

Address_____ **Insured SS#**_____

Phone_____ **Date of Birth**_____

Who should receive bills for payment on your account?

☐ Patient ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Personal Insurance

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for the examination of X-Rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain; some go to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care – Symptomatic relief of pain or discomfort.

☐ Corrective Care – Correcting and relieving the cause of the problem as well as the symptoms.

☐ Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient Signature **Date** **Guardian/Spouse Signature** **Date**