# Smith Chiropractic Clinic

**PATIENT INFORMATION** Today's Date: ____________

Name: _______________________________________________Date of Birth: _______________

Address: ___________________________ City: _________________ State: ________ Zip:________

Email Address: ___________________________________________

Home Phone: _______________________Work Phone: _____________________

Social Security #:____________________ Age: _______ ❑ Male ❑ Female

Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated ❑Other __________

Name of Spouse or Nearest Relative: _________________________ Phone: ________________

Your Occupation____________________________ Your Employer: _______________________

Referred to this Office by: ❑Friend/Family Member - Name? __________________________

❑Yellow Pages ❑ Mail ❑Clinic Location ❑Other__________

Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance

❑Automobile Insurance ❑Worker'sCompensation

Name of Insurance Co.: _____________________________Insured's Employer: ______________ Insured's Social Security #:_____________________

Employer's Phone #:__________

Are you covered by more than one insurance company? ❑Yes ❑No Name _________________

**MEDICAL/FAMILY HISTORY** S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

| S | M | F | | S | M | F | |
|---|---|---|---|---|---|---|---|
| ❑ | ❑ | ❑ | AIDS | ❑ | ❑ | ❑ | dislocated joints |

❑ ❑ ❑ anemia ❑ ❑ ❑ epilepsy
❑ ❑ ❑ arthritis ❑ ❑ ❑ German measles
❑ ❑ ❑ asthma ❑ ❑ ❑ headaches
❑ ❑ ❑ back pain ❑ ❑ ❑ heart trouble
❑ ❑ ❑ bladder trouble ❑ ❑ ❑ reproductive disorders
❑ ❑ ❑ bone fracture ❑ ❑ ❑ high blood pressure
❑ ❑ ❑ cancer ❑ ❑ ❑ HIV/ARC
❑ ❑ ❑ kidney disorder ❑ ❑ ❑ scarlet fever
❑ ❑ ❑ concussion ❑ ❑ ❑ bowel control loss
❑ ❑ ❑ convulsions ❑ ❑ ❑ menstrual cramps
❑ ❑ ❑ diabetes ❑ ❑ ❑ multiple sclerosis
❑ ❑ ❑ indigestion ❑ ❑ ❑ muscular dystrophy

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition________________________________________ Date of Last Physical Exam__________

SURGICAL HISTORY:

1.________________________________________________ Date: _________________
2.________________________________________________ Date: _________________
3.________________________________________________ Date: _________________

Have you ever had a metal implant? ❑Yes ❑No

ACCIDENT HISTORY : ❑Job ❑Auto ❑Other
1. ___________________________ Date: _________________
❑Job ❑Auto ❑Other
2.____________________________Date:__________________
❑Job ❑Auto ❑Other
3.____________________________Date:__________________

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:** Please Rate Your symptoms(1-10, with 1 being least serious)

1.__________________________________________________________________
_________

2.__________________________________________________________________
_________

3.__________________________________________________________________
_________

4.__________________________________________________________________
_________

5.__________________________________________________________________
_________

6.___________________________________________________________
________

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

WHEN AND HOW OCCURRED?
______________________________________________________________

______________________________________________________________
SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT
❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED: ___________________
SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)
SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT
HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?
______________________________________
IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?
_____________________________________________________
____________________________________
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
___________________________________________________________________________
_____________
___________________________________________________________________________
_____________
ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?
_____________________________
ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?
____________________________
ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD____________

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD
❑REACHING ❑WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss/confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Patient's Signature: ___________________________________ Date: