----------PERSONAL INFORMATION----------

Name:_____ Date of birth:_____ Gender: Male___ Female___

Primary Phone#_____ Cell Phone #_____

Address: _____ City/State/Zip_____

Email: (used for patient communication, not sold to third parties)_____

Employment status: Employed__ Self Employed__ Retired__ FT Student__ PT Student__ Other__

Employer:_____ Work Phone:_____

Marital Status: Single__ Married__ Other__ Spouse Name:_____ Spouse Employer:_____

Emergency Contact Name, Phone, and Relationship:_____

Insurance holder's name:_____ Insurance holder's date of birth:_____

How were you referred to this office? _____

Verification question - Circle one question **below**, then give answer **here**: (at least 6 characters)_____

What street did you grow up on? In what city were you born? What high school did you attend?

----------CURRENT COMPLAINT----------

Purpose of this appointment (**What is your goal?)**:_____

Is this condition: ___Job Related ___Auto Accident ___Sports Injury ___Chronic ___Other:_____

How & When did your pain begin?_____

Have you had any Tests (X-ray/MRI)? When and Where?_____

What treatment have you had for this condition?_____

Has this Condition occurred before? __No __Yes If Yes, when?_____

What makes it better?_____ What makes it worse?_____

----------PAST MEDICAL HISTORY----------

Previous Chiropractic Care: No___ Yes___ Doctor's name and last visit_____

Surgeries/Hospitalizations and Dates_____

_____

Trauma History (Falls, Car accidents, Sports injuries)_____

_____

Other conditions/info you'd like us to know about _____

----------GENERAL HEALTH----------

Family Doctor Name _____ May we contact if necessary? Yes__ No__

Current medications: Include below name, dosage and times per day. If no current medications, check here: _____

_____ _____ _____

_____ _____ _____

List any known allergies to medications: _____If no allergies are known, check here: _____

Is your job mostly: Sitting? Standing? Mixed?_____ How long is commute? _____each way

Sleep Positions and how long do you sleep at night?_____

Exercise:_____ How Many Times per week?_____

Stress Level: Low__ Medium__ High__ If High, why?_____

----------WHY CHIROPRACTIC? ----------

People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so that Dr. Smith may be guided by your wishes whenever possible.

Stage 1 ___ Pain relief: Just get rid of the pain, Doc! Relief is short-term.

Stage 2 ___ Rehabilitation: Get rid of the pain, Doc, but then fix this problem so that it doesn't come back!

Stage 3 ___ Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible.

----------Medical History(Check all that apply) ----------

General
- — Fever/Chills
- — Night Sweats
- — Loss of sleep
- — Fatigue
- — Nervousness
- — Weight loss or gain
- — Bleeding problem
- — Anemia
- — Diabetes
- — Cancer
- — Thyroid disease/ goiter
- — Alcoholism
- — Drug abuse

Eye/Ear/Nose/Throat
- — Poor vision
- — Pain in the eye(s)
- — Deafness
- — Nosebleeds/Nose problems
- — Sinus trouble
- — Dental problems
- — Hoarseness
- — Tonsillectomy

Gastrointestinal
- — poor appetite
- — poor digestion
- — difficulty swallowing
- — belching or gas
- — frequent nausea
- — vomiting
- — vomiting blood
- — pain over abdomen
- — ulcer
- — black or bloody stools
- — liver problems/jaundice
- — gall bladder problems
- — hernia
- — diarrhea
- — constipation
- — hemorrhoids
- — appendicitis

Respiratory
- — Difficulty breathing
- — Chronic cough
- — Spitting phlegm/mucus/blood
- — Wheezing/ asthma
- — Pneumonia
- — Tuberculosis

Cardiovascular
- — Irregular heartbeat
- — High blood pressure
- — Pain over heart
- — Previous heart trouble
- — Ankle swelling
- — Varicose veins
- — Rheumatic fever
- — Stroke

Genitourinary
- — Frequent urination
- — Blood in urine
- — Kidney disease
- — Urinary infection
- — Inability to control urination
- — Difficulty starting urine
- — Get up ___ times per night
- — Breast lump or pain

Skin
- — Itching
- — Bruising easy
- — Change in mole
- — Skin cancer

Family History
- — Diabetes
- — Thyroid disease/goiter
- — Tuberculosis
- — Kidney disease
- — High blood pressure
- — Heart disease
- — Cancer
- — Muscle, bone or nerve disease

Neurologic
- — Weakness
- — Twitching/Tremors
- — Headache
- — Fainting
- — Dizziness
- — Convulsions
- — Epilepsy
- — Numbness/ tingling
- — Arm/leg pain
- — Mental disorder

Musculoskeletal
- — Neck stiffness/pain
- — Pain between shoulder
- — Low back pain
- — Swollen or painful joints
- — Muscle aches/ soreness
- — Spinal curvature
- — Arthritis

Habits
- — Smoking __packs per day
  __years
- — Drinking
- — Recreational drug use

Exercise
- — None
- — _____ times per week
- — Type of exercise_____

Women Only
- — Painful periods
- — Excessive flows
- — Irregular cycles
- — Hot flashes
- — Date of last period_____

Men only
- — Testicular swelling
- — Prostate problems

Height_____ Weight _____

Known Allergies: _____ _____ _____ _____ OR none known ___