Patient's Full Name:_________________________________ Date:______________

Welcome to Smith Chiropractic

Case History

Name ____ Date of Birth ______________

Telephone # (Home) ______________ (Work)__________________ (Cell)__________________

Email: ____

Address_________________________________ City/State/ZIP_____________________________

Occupation_____________________________ Employer_____________________________

Insurance Co. ___________________________ Referred by: ______________________________

Marital Status: □ **S**; □ **M**; □ **D**; □ **W** Spouse's Name __________________ # of Children____

Past Chiropractic Care? □ **Yes**; □ **No** When? _________ Doctor's Name _________________

Medical Doctor's Name _____________________________ Last Visit _____________________

What brings you in today?____

Please indicate your pain level today on a scale from 0-10 (0 being no pain at all and 10 being excruciating pain)
□ **1** □ **2** □ **3** □ **4** □ **5** □ **6** □ **7** □ **8** □ **9** □ **10**

Pain is made: Worse by:_________________________ Better by:__________________________

Pain description: (please circle one)

Ache Sharp Throb Dull Shooting Stiff Tight

Does the pain radiate? If so, where does it radiate to? ___________________________________

Pain prevents me from: (please circle one)

Sitting Standing Walking Bending Sleeping Working Daily life

Are your present symptoms due to any of the following?

□ auto accident □ work injury □ an accident □ a trauma □ an illness

□ an aggravating of a congenital problem □ unknown factors

Date of symptom first appeared _____________Have you ever experienced this before?______

Are you currently in a work comp case? □ **Yes**; □ **No**

Patient's Full Name:__________________________________ Date:_______________

Are you currently in an auto accident case? □ **Yes**; □ **No**

Are you now, or have you ever been, disabled? (service or work) □ **Yes**; □ **No**

If yes, when ______________________ How ____

Please check any and all of the following conditions that pertain to you. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

______ Decreased Activity Level
______ Fever
______ Chills
______ Fatigue
______ Night Sweats
______ Loss of Appetite
______ Weight Loss
______ Weight Gain
______ Loss of Energy
______ Uncontrolled Sweating

Mental Health Problems

______Irritability
______Depression
______Disturbed Sleep
______Suicidal Thoughts
______ Anxiety
______ Nervousness

Trouble Urinating?

______ Frequent Urination
______ Urgency
______ Trouble with Stream
______ Erectile Dysfunction
______ Nocturia
______ Burning w/ Urination
______ Losing Control
______ Bowel Dysfunction
______ Sexual Dysfunction

Trouble with Vision

______ Blurred Vision
______ Double Vision
______ Vision Loss
______ Eye Pain
______ Glasses/Contacts

Heart Troubles

______ Chest Pain
______ Palpitations
______ Fainting
______ Shortness of Breath
______ Ankle Swelling

Breathing Troubles

______ Coughing
______ Wheezing
______ Shortness of Breath

Stomach Problems

______ Nausea
______ Vomiting
______ Diarrhea
______ Constipation
______ Loss of Bowel Control

Muscle/Joint Problem

______ Joint Pain
______ Joint Weakness
______ Muscle Weakness

Skin Problems

______ Rash
______ Itching
______ Dryness
______ Lesions
______ Infections

Immunity Problems

______ Enlarged Lymph Nodes
______ Hives
______ Hay Fever
______ Persistent Infections

Endocrine Problems

______ Diabetes
______ Thyroid Disorder

Neurological Problems

______ Seizures
______ Loss of Feeling
______ Loss of Memory

Bleeding Problems

______ History of Anemia
______ Heat Intolerance
______ Abnormal Bleeding
______ Cold Intolerance
______ Bruising

Patient's Full Name:___________________________________ Date:_______________

Please list current medications and doses on the line below:

____
____

Please list any surgeries and their dates on the line below:

____
____

Past History

Check on all past and present medical health problems that you may have.

_____ Diabetes _____ Lung Disease _____ Stomach Problem_____ Ulcer Disease
_____Kidney Disease _____ Heart Defects _____ High Cholesterol _____ Liver Problems
_____ Asthma _____ Bleed Easily _____ Arthritis _____ Cancer
_____ Other, Please explain: ____
____

Family and Social History

Indicate if your parents, sisters or brothers have any of the following problems: (M=Mother, F= Father, B= Brother, S= Sister)

_____ Arthritis _____ High Blood Pressure _____ High Cholesterol
_____ Diabetes _____ Depression _____ Heart Disease
_____ Cancer _____ Chronic Pain _____ Other

Please explain below if the answer is other:

____
____

Are you working? □ Yes □ No

What Best Describes your type of Work? (select the best answer)

□ Retired □ Not Employed □ Sedentary Duty □ Light Duty □ Medium Duty □ Heavy Duty

Do you drink alcohol?

□ Never □ Occasionally □ Socially □ Frequently (more than 3 days per week)

Have you had substance abuse treatment?

□ Yes □ No

Have you ever used Illegal drugs?

□ Yes □ No

Do you smoke or use tobacco products?

□ Yes □ No

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only.

Patients Signature X____ Date _______________

Guardian or Spouse's
Signature authorizing Care ____ Date _______________