JODY SMITH CHIROPRACTIC

Patient Registration & Health History

In order to provide you the best possible wellness care, please complete this entire form.
All information is strictly **CONFIDENTIAL.**

1 PATIENT INFORMATION

Date________________________

Name____

Address____

City__________________ State_____ Zip__________

Social Security #____________________________________

Sex ☐M ☐F Age_____ Birthdate_________________

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Number of Children_______

Occupation____

Employer____

Spouse's Name_______________________________________

Spouse's Occupation__________________________________

Spouse's Employer____________________________________

Spouse's Health Status_________________________________

Whom may we thank for referring you?________________

____

2 INSURANCE INFORMATION

Who is responsible for payment?______________________

Phone______________________ ☐Home ☐Work ☐Cell

Do you have health insurance? ☐Y ☐N

Insurance Co.____

Group #_______________

***If an auto accident, please provide:**

Insurance Company Name___________________________

Contact Person______________________________________

Phone________________ Claim #__________________

Name of the insured_________________________________

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Spouse's or Guardian's Signature Date

3 PHONE & EMAIL

Home__________________ Work____________________
ext______

Cellular__________________

Email____

Jody Smith Chiropratic will NOT share your email address with any 3rd party. It will only be used to for occasional office announcements and promotions.

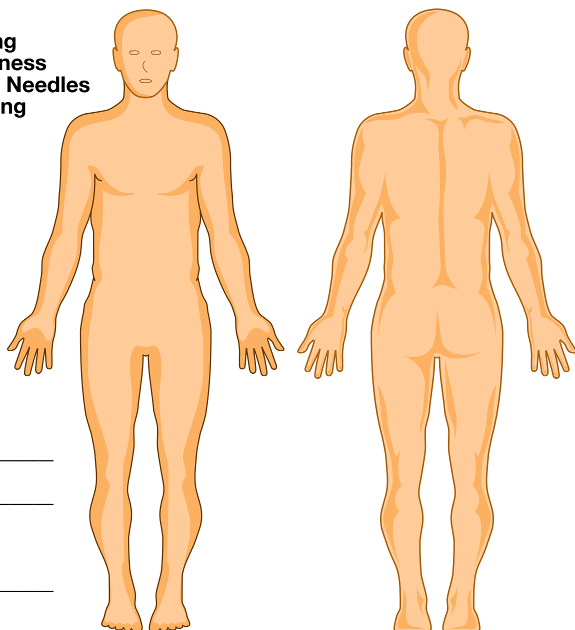
IN CASE OF EMERGENCY, CONTACT:

Name______________________ Phone______________

4 CURRENT COMPLAINTS

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A = Ache
B = Burning
N = Numbness
P = Pins & Needles
S = Stabbing
O = Other



Nature of your injury: ☐Automobile ☐Work ☐Sports ☐Other

Please describe:____

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Date of Injury_____________ Date symptoms appeared____________

Have you ever had same condition? ☐Yes ☐No If yes, when?____________

List other practitioners seen for this injury/condition______________________

Have you ever been under chiropractic care? ☐Yes ☐No

If yes, please describe____

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5 MEDICAL HISTORY

Have you been treated for any conditions in the last year? ☐ Yes ☐ No If yes, please describe________________________________

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Date of last physical exam______________ Is there a chance that you are pregnant? ☐ Yes ☐ No

Have you had X-rays taken? ☐ Yes ☐ No If Yes, where?____

What medications are you taking and for what conditions (Please list dosage and amounts, etc):____________________________

____

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency):______________

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Have You Ever:	Yes	No	Briefly Explain
Broken bones?	☐	☐	________________
Been hospitalized?	☐	☐	________________
Been in an auto accident?	☐	☐	________________
Had sprains / strains?	☐	☐	________________
Been struck unconscious?	☐	☐	________________
Had surgery?	☐	☐	________________

Pain Survey:	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse certain times of day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

Family History:

Family Members - Present and past health conditions
(Example: heart disease, cancer, diabetes, arthritis, etc.)

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Have You Ever Suffered From: *(Check all that apply)*

GENERAL:
☐ Fever
☐ Chills
☐ Night Sweats
☐ Loss of Sleep
☐ Fatigue
☐ Nervousness
☐ Weight Loss/Gain
☐ Allergies
☐ Bleeding Problems
☐ Anemia
☐ Diabetes
☐ Cancer
☐ Thyroid Disease
☐ Alcoholism
☐ Drug Abuse

RESPIRATORY:
☐ Difficulty Breathing
☐ Chronic Cough
☐ Spitting Phlegm
☐ Spitting Blood
☐ Wheezing/Asthma
☐ Pneumonia
☐ Tuberculosis

MUSCULOSKELETAL:
☐ Neck Stiffness
☐ Pain Between Shoulders
☐ Low Back Pain
☐ Swollen Joints
☐ Muscle Aches/Soreness
☐ Spinal Curvature
☐ Arthritis

NEUROLOGIC:
☐ Weakness
☐ Twitching
☐ Tremors
☐ Headache
☐ Fainting
☐ Dizziness
☐ Convulsions
☐ Epilepsy
☐ Numbness
☐ Arm/Leg Pain
☐ Mental Disorder

MEN ONLY:
☐ Testicular Swelling/Pain
☐ Prostate Problems
☐ Erectile Dysfunction

EYE/EAR/NOSE/THROAT:
☐ Poor Vision
☐ Pain in Eye(s)
☐ Deafness
☐ Difficulty Hearing
☐ Nose Bleeds
☐ Nose Problems
☐ Sinus Trouble
☐ Dental Problems
☐ Hoarseness
☐ Tonsillectomy

SKIN:
☐ Itching
☐ Bruising Easily
☐ Change in Mole(s)
☐ Skin Cancer

CARDIOVASCULAR:
☐ Irregular Heartbeat
☐ High Blood Pressure
☐ Pain Over Heart
☐ Previous Heart Trouble
☐ Ankle Swelling
☐ Varicose Veins
☐ Rheumatic Fever
☐ Stroke

WOMEN ONLY:
☐ Painful Periods
☐ Excessive Flow
☐ Irregular Flow
☐ Vaginal Burning/Itching
☐ Hot Flashes
☐ Lumps in Breast

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5 MEDICAL HISTORY CONTINUED...

Have You Ever Suffered From Continued: *(Check all that apply)*

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
- ☐ Gall Bladder Problems
- ☐ Jaundice
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Appendicitis

GENITOURINARY

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Disease
- ☐ Urinary Infection
- ☐ Urination Control Problem
- ☐ Difficulty Starting Urine
- ☐ Get up at night to Urinate
- ☐ Breast Lump or Pain
- ☐ Venereal Infection
- ☐ Sexual Difficulties

FAMILY HISTORY

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Muscle, Bone or Nerve Disease

6 QUESTIONS OR COMMENTS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR

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7 DOCTOR'S NOTES

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