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

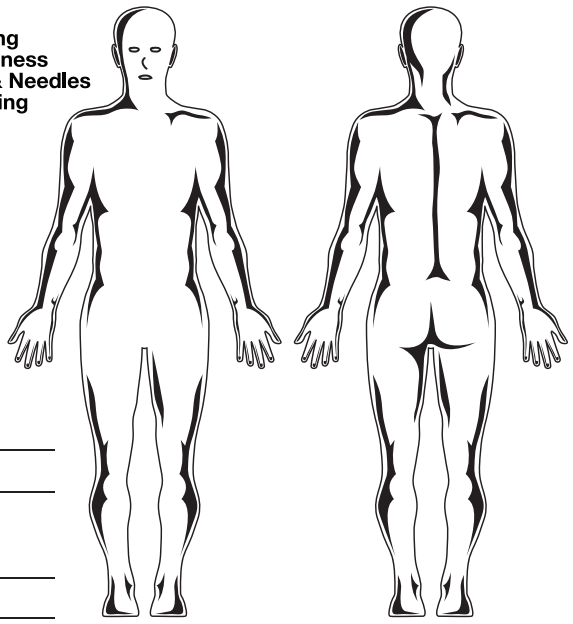
IN CASE OF EMERGENCY, CONTACT:

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:_____

_____

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_____

_____

Continued on next page...

[redacted]

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

_____

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 (Pl

[redacted]

[redacted]

[redacted]

[redacted]

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

7 DOCTOR'S NOTES