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_________________________________

Who is your Primary Care Physician? _______________

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 #_______________

I understand and agree that health 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___________________

Cellular___________________ ext_____

Email____

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

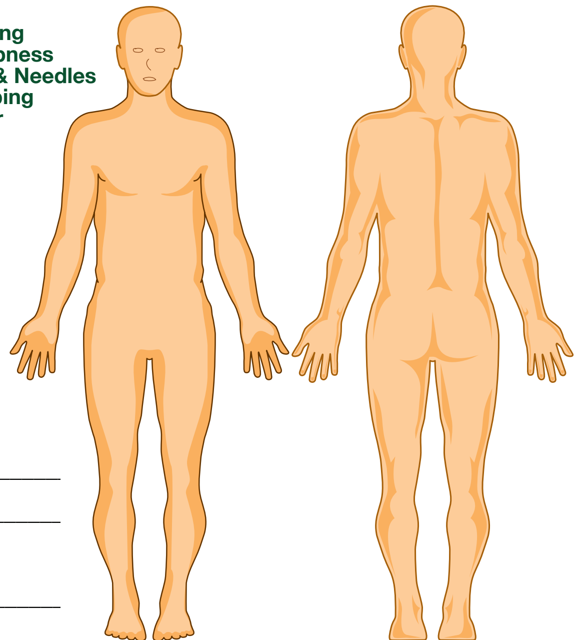
IN CASE OF EMERGENCY, CONTACT:

Name______________________ Phone______________

4 CURRENT COMPLAINTS

Please use the following letters to indicate the **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...

5 MEDICAL HISTORY

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 (Please list dosage and amounts, etc):______________________________

____

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

____

List any known allergies: ____

In Last 3 Years Have You:	Yes	No	Briefly Explain
Had any 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?	☐	☐

Family History:

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

____

____

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

*If *current* smoker, how many packs?____________________

*If *former* smoker, what year did you quit? ________________

In The Last 3 Years Have You Suffered From: *(Check all that apply)*

GENERAL:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight Loss/Gain
- ☐ 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

NEUROLOGICAL:
- ☐ 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

Continued on next page...

5 MEDICAL HISTORY CONTINUED...

In The Last 3 Years Have You Suffered From: *(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