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_____

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 PHONE & EMAIL

Home_____ Work_____

Cellular_____ ext_____

Email_____

IN CASE OF EMERGENCY, CONTACT:

Name_____

Phone_____ Relation _____

3 INSURANCE INFORMATION

Do you have health insurance? ☐Y ☐N

Insurance Co._____

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.

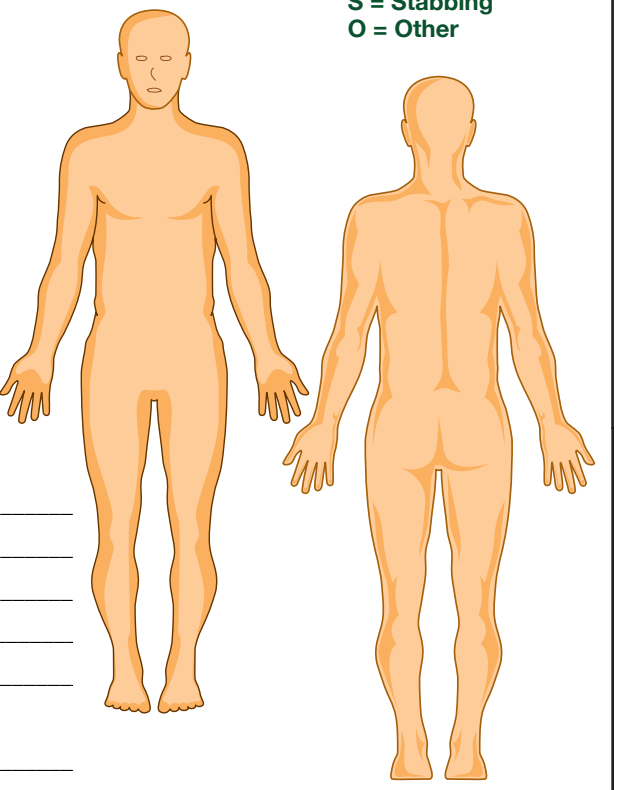
_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian's Signature Date

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



Briefly explain what brings you in today

_____

_____

Date of injury (if any) _____ 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