

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

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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? _____

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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 _____

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PHONE & EMAIL

Home _____ Work _____

Cellular _____ ext _____

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:

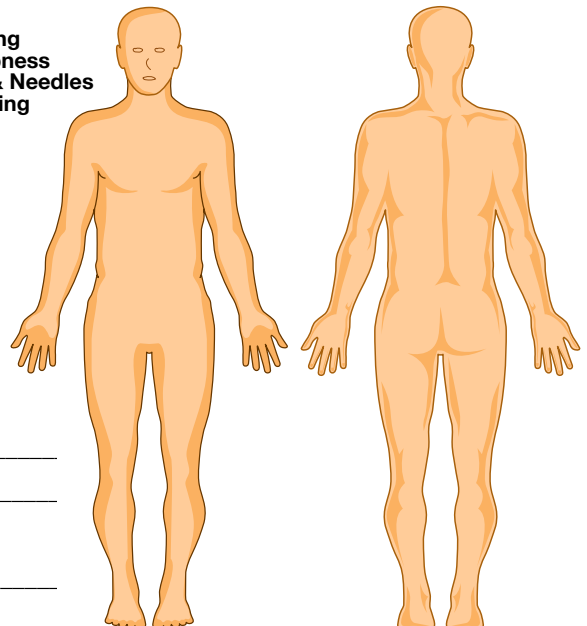
Name _____ Phone _____

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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 _____

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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): _____

Have You Ever:	Yes	No	Briefly Explain
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an auto accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had sprains / strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Pain Survey:	Yes	No
Do you experience pain every day?	<input type="checkbox"/>	<input type="checkbox"/>
Do your symptoms interfere with daily life?	<input type="checkbox"/>	<input type="checkbox"/>
Does pain wake you up at night?	<input type="checkbox"/>	<input type="checkbox"/>
Are your symptoms worse certain times of day?	<input type="checkbox"/>	<input type="checkbox"/>
Do changes in weather affect your symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear orthotics?	<input type="checkbox"/>	<input type="checkbox"/>

Habits:	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family History:

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

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

