Date:_____

Welcome to Smith Chiropractic

Case History

Name _____ Date of Birth _____

Telephone # (Home) _____ (Work)_____ (Cell)_____

Email: _____

Address_____ City/State/ZIP_____

Occupation_____ Employer_____

Insurance Co. _____ Referred by: _____

Marital Status: □ **S**; □ **M**; □ **D**; □ **W** Spouse's Name _____ # of Children____

Past Chiropractic Care? □ **Yes**; □ **No** When? _____ Doctor's Name _____

Medical Doctor's Name _____ Last Visit _____

Recent Imaging? □ **Yes**; □ **No** Details:_____

What brings you in today? _____

Please indicate your pain level today on a scale from 0-10 (0 being no pain at all and 10 being excruciating pain)

□ **1** □ **2** □ **3** □ **4** □ **5** □ **6** □ **7** □ **8** □ **9** □ **10**

Pain is made: Worse by: _____ Better by:_____

Pain description: (please circle one)

Ache Sharp Throb Dull Shooting Stiff Burning

Does the pain radiate? If so, where does it radiate to? _____

Numbness or tingling? Please explain: _____

Pain prevents me from: (please circle one)

Sitting Standing Walking Bending Sleeping Working Daily life

Are your present symptoms due to any of the following?

□ auto accident □ work injury □ an accident □ a trauma □ an illness

□ an aggravating of a congenital problem □ unknown factors □ other _____

Date of symptom first appeared _____ Have you ever experienced this before? □ **Yes**; □ **No**

Are you currently in a work comp case? □ **Yes**; □ **No**

Are you currently in an auto accident case? □ **Yes**; □ **No**

Any past history of auto accidents? □ **Yes**; □ **No**

Are you now, or have you ever been, disabled? (service or work) □ **Yes**; □ **No**

If yes, when _____ Reason: _____

Patient's Full Name:_____ Date:_____

Please check any and all of the following conditions that pertain to you. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

_____ Decreased Activity Level
_____ Fever
_____ Chills
_____ Fatigue
_____ Night Sweats
_____ Loss of Appetite
_____ Weight Loss
_____ Weight Gain
_____ Loss of Energy
_____ Uncontrolled Sweating

Mental Health Problems

_____ Irritability
_____ Depression
_____ Disturbed Sleep
_____ Suicidal Thoughts
_____ Anxiety
_____ Nervousness

Trouble Urinating?

_____ Frequent Urination
_____ Urgency
_____ Trouble with Stream
_____ Erectile Dysfunction
_____ Nocturia
_____ Burning w/ Urination
_____ Losing Control
_____ Bowel Dysfunction
_____ Sexual Dysfunction

Trouble with Vision

_____ Blurred Vision
_____ Double Vision
_____ Vision Loss
_____ Eye Pain
_____ Glasses/Contacts

Heart Troubles

_____ Chest Pain
_____ Palpitations
_____ Fainting
_____ Shortness of Breath
_____ Ankle Swelling

Breathing Troubles

_____ Coughing
_____ Wheezing
_____ Shortness of Breath

Stomach Problems

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Loss of Bowel Control

Muscle/Joint Problem

_____ Joint Pain
_____ Joint Weakness
_____ Muscle Weakness

Skin Problems

_____ Rash
_____ Itching
_____ Dryness
_____ Lesions
_____ Infections

Immunity Problems

_____ Enlarged Lymph Nodes
_____ Hives
_____ Hay Fever
_____ Persistent Infections

Endocrine Problems

_____ Diabetes
_____ Thyroid Disorder

Neurological Problems

_____ Seizures
_____ Loss of Feeling
_____ Loss of Memory

Bleeding Problems

_____ Abnormal Bleeding
_____ Cold Intolerance

_____ History of Anemia
_____ Heat Intolerance

_____ Bruising

Patient's Full Name:_____ Date:_____

Please list current medications and doses on the line below:

_____

_____

Past History

Check on all past and present medical health problems that you may have.

_____ Diabetes _____ Lung Disease _____ Stomach Problem _____ Ulcer Disease

_____ Kidney Disease _____ Heart Defects _____ High Cholesterol _____ Liver Problems

_____ Asthma _____ Bleed Easily _____ Arthritis _____ Cancer

_____ Stroke _____ Other, please explain:

_____

_____

Please list any surgeries and their dates on the line below:

_____

_____

Family and Social History

Indicate if any close family have any of the following problems: (M=Mother, F= Father, B= Brother, S= Sister)

_____ Arthritis _____ High Blood Pressure _____ High Cholesterol

_____ Diabetes _____ Depression _____ Heart Disease

_____ Cancer _____ Chronic Pain _____ Stroke _____ Other

Please explain below if the answer is other:

_____

_____

Are you working? □ Yes □ No

What Best Describes your type of Work? (select the best answer)

□ Retired □ Not Employed □ Sedentary Duty □ Light Duty □ Medium Duty □ Heavy Duty

Do you drink alcohol?

□ Never □ Occasionally □ Socially □ Frequently (more than 3 days per week)

Have you had substance abuse treatment?

□ Yes □ No

Do you smoke or use tobacco products?

□ Yes, Frequency and duration: _____

□ Previous, Frequency and duration:_____

□ No

Have you ever used Illegal drugs?

□ Yes □ No

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only.

Patient, Guardian, or Spouse's Signature Authorizing Care: Date:

_____ _____

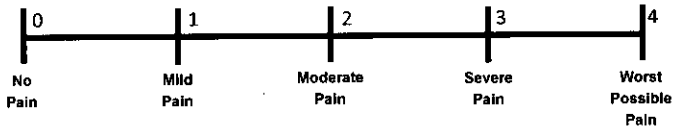
Patient name:_____ Date:_____

Functional Rating Index

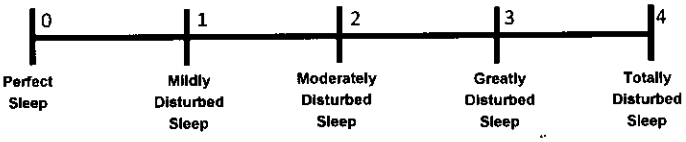
In order to properly assess your condition, we must understand how much your pain has affected your ability to manage everyday activities. For each item below,

please circle the number which most clearly describes your condition right now.

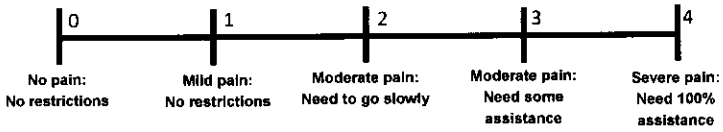
1. Pain Intensity



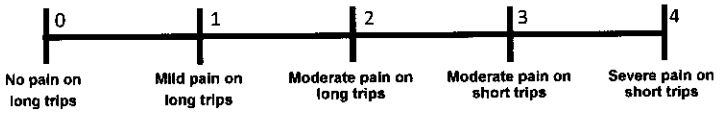
2. Sleeping



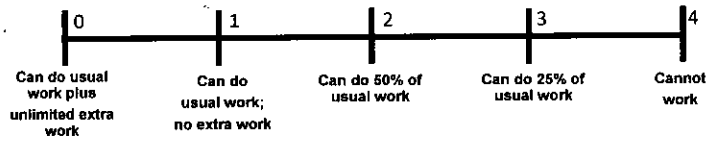
3. Personal Care (washing, dressing, etc.)



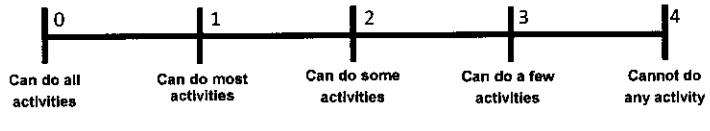
4. Traveling (driving, sitting, etc.)



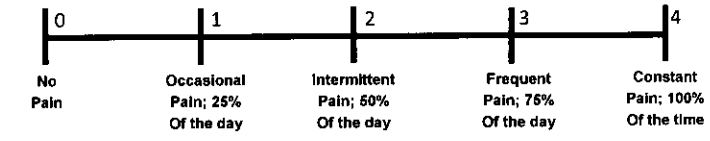
5. Work



6. Recreation



7. Frequency of Pain



8. Lifting

9. Walking

10. Standing

Total score:_____/40

Patient signature:_____ Date:_____