smith
Health Wellness
Chiropractic

Patient Information

Date _____

SS/HIC/Patient ID# _____

Patient Name _____
Last

_____
First Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex ❑ M ❑ F Age _____

Birth date _____

Status:

❑ Single ❑ Married ❑ Separated ❑ Divorced

❑ Widowed ❑ Partnered ❑ Minor

Occupation _____

Work Number _____

Employer/School Phone _____

Spouse's Name _____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (___) _____

Cell Phone (___) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (___) _____

Cell Phone (___) _____

Insurance

Who is responsible for this account? _____

Insurance Co. _____

Member ID# _____

Group # _____

Subscriber's Name _____

Relationship to Insured _____

Subscriber Birth Date _____

Is patient covered by additional insurance ❑ Yes ❑ No

Secondary Insurance Co. _____

Member ID# _____

Group # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Accident Information

Is condition due to an accident? ❑ Yes ❑ No

Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Workers Comp. ❑ Other

Attorney Name (if applicable)

_____

_____

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Dear Patient,

Due to policy provisions in your contract with your insurance carrier, Smith Health and Wellness is obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, coinsurances, or copayments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, Smith Health and Wellness is legally obligated to collect the patient responsibility coinsurance, copayment or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance, we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Yours in Health!

Signature:_____Date:_____

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History of Presenting Illness

Patient Name:_____**File#:**_____**Date:**_____

Date of Birth:_____/_____/_____ **Height:** _____ **Weight:** _____

Reason for seeking care: _____

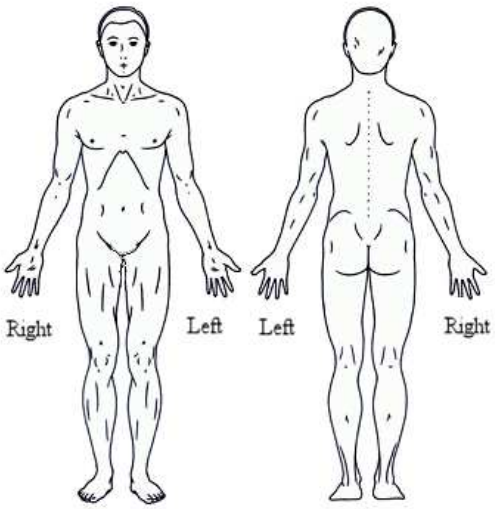
What were you doing that caused this condition? _____

Circle your degree of pain, 0 = none, 10 = severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^



When did this problem start?_____

What activities aggravate your condition/pain?_____
_____

What activities lessen your condition/pain?_____
_____

Is this condition worse during certain times of the day? Y / N When_____ How Long?_____

Is this condition interfering with: Work?____ Sleep?____ Driving? _____ Sitting? _____Walking?_____ Lifting? _____
Other?_____

Is this condition progressively getting worse? Y / N

Is it BETTER with Warm Temp / Cold Temp or WORSE with Warm temp / Cold Temp

Do you have any radiating symptoms? Left / Right / Both sides _____

Do you notice any muscle weakness? Left / Right / Both sides _____

Do you have any associated signs or symptoms? Blurred vision / Depression / Dizziness / Irritability/Mood Swings

Nausea / Localized Tingling / Ringing in Ears / Sleep Disturbance / Stiffness / Headaches

PAST HISTORY

Have you seen any other doctors for this? _____

Have you had similar symptoms before? __ Yes __ No If yes, explain: _____

Have you received chiropractic treatment previously? YES / NO For what:_____

Do you have any allergies? _____

List ALL medications you are CURRENTLY taking

Medication	Dosage	For what condition	How long been taking

List ALL supplements you are CURRENTLY taking

Supplements	Dosage	For what condition if any	How long been taking

Family History

Members of my family suffer from the following: M = Mother / F = Father / S=Sister / B=Brother

__ Thyroid Issues __ Heart Trouble __ Kyphosis __ Diabetes __ Cancer __ Arthritis
__ Lung Disease __ Osteoporosis __ Migraines __ Scoliosis __ High Blood Pressure
__ Stroke __ Mental Illness __ Hypertension __ Alcohol Dependence __ Spinal Problems
__ Other_____

Social History

What types of food do you eat?_____

Do you exercise? Y / N How many times per week_____

Do you drink alcohol? Y / N What kind? _____How many per week_____

Do you use tobacco? Y / N What kind? _____How many per day/week? _____How long? _____

Are you sexually active? _____

Do you use recreational drugs? _____

How many hours of sleep on average do you get each night? _____

Childhood Illness(es): Check all health conditions.

- ❑ ADD
- ❑ atopic dematitis (eczema)
- ❑ allergies/hayfever
- ❑ anemia
- ❑ asthma
- ❑ bedwetting
- ❑ ceredral palsy
- ❑ chicken pox
- ❑ crohn's/colitis
- ❑ depression
- ❑ diabetes
- ❑ ear infections
- ❑ fetal drug exposure
- ❑ food allergies (list below)
- ❑ headaches
- ❑ hepatitis
- ❑ HIV
- ❑ measles
- ❑ mumps
- ❑ psoriasis
- ❑ rash
- ❑ scoliosis
- ❑ seizure disorder
- ❑ sickle cell anemia
- ❑ spina bifida
- ❑ other:

Do you believe that the Adult Illness listed below are contributory to your CURRENT Condition? ❑ Yes ❑ No

Adult Illness(es): Check all health conditions.

- ❑ ADD
- ❑ alzheimers
- ❑ anemia
- ❑ arthritis
- ❑ asthma
- ❑ cancer
- ❑ cerebral palsy
- ❑ chicken pox
- ❑ crohn's/colitis
- ❑ CRPS (RSD)
- ❑ CVA (stroke)
- ❑ cystic kidney disease
- ❑ depression
- ❑ diabetes (insulin dep)
- ❑ diabetes (no insulin)
- ❑ eczema
- ❑ emphysema
- ❑ eye problems
- ❑ fibromyalgia
- ❑ heart disease
- ❑ hepatitis
- ❑ HIV
- ❑ hypertension
- ❑ influenzal pneumonia
- ❑ liver disease
- ❑ lung disease
- ❑ lupus erythema (discoid)
- ❑ lupus erythema (systemic)
- ❑ multiple sclerosis
- ❑ parkinson's disease
- ❑ unspecific pleural effusion
- ❑ pneumonia
- ❑ psoriasis
- ❑ psychiatric problems
- ❑ scoliosis
- ❑ seizures
- ❑ shingles
- ❑ past history of similar symptoms
- ❑ STDs (unspecified)
- ❑ suicide attempt(s)
- ❑ thyroid problems
- ❑ vertigo
- ❑ other:

Surgery(ies): Check all surgeries.

- ❑ angioplasty
- ❑ appendectomy
- ❑ caesarian section
- ❑ cardiac catheterization
- ❑ carpal tunnel repair
- ❑ coronary artery bypass
- ❑ cosmetic
- ❑ D&C
- ❑ dental surgery
- ❑ gall bladder
- ❑ hemorrhoidectomy
- ❑ hernia repair
- ❑ hysterectomy
- ❑ joint reconstruction
- ❑ joint replacement
- ❑ knee repair
- ❑ laminectomy
- ❑ mastectomy
- ❑ pacemaker insertion
- ❑ rotator cuff
- ❑ spinal fusion
- ❑ tonsilectomy
- ❑ other:

Injury(ies): Check all injuries.

- ❑ back injury
- ❑ broken bones
- ❑ disability(ies)
- ❑ fall (severe)
- ❑ fracture
- ❑ head injury (loss of consciousness)
- ❑ head injury (no loss of consciousness)
- ❑ industrial accident
- ❑ joint injury
- ❑ laceration (severe)
- ❑ motor vehicle accident
- ❑ soft tissue injury(mild)
- ❑ soft tissue injury(moderate)
- ❑ soft tissue injury(severe)
- ❑ other:

Immunizations: Check all immunizations.

- ❑ adenovirus
- ❑ anthrax
- ❑ botulism
- ❑ diphtheria
- ❑ DTaP (diphtheria, tetanus, pertussis)
- ❑ flu
- ❑ haemophilus B
- ❑ hepatitis A
- ❑ hepatitis B
- ❑ hepatitis C
- ❑ influenza
- ❑ IPV (polio)
- ❑ Japanese encephalitis
- ❑ lyme disease
- ❑ measles
- ❑ meningococcal
- ❑ MMR
- ❑ mumps
- ❑ pertussis
- ❑ pneumococcal
- ❑ pneumovax
- ❑ PPD (mantoux test- TB)
- ❑ rabies
- ❑ rotavirus
- ❑ rubella
- ❑ smallpox
- ❑ tetanus
- ❑ tuberculosis
- ❑ tularemia
- ❑ typhoid
- ❑ varivax (chicken pox)
- ❑ whooping cough (pertussis)
- ❑ yellow fever
- ❑ other:

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Fever
__ Chills
__ Fatigue
__ Night Sweats
__ Weight Gain
__ Weight Loss

NEURO/MUSCLES
__ Facial Weakness
__ Headaches
__ Limb Weakness
__ Loss of Consciousness
__ Loss of Balance
__ Loss of Memory
__ Numbness/Tingling
__ Seizures
__ Sleep Disturbance
__ Slurred Speech
__ Stress
__Tremors/Shaking

CARDIO-VASCULAR
__ High Blood Pressure
__ Low Blood Pressure
__ Heart Attack
__ Shortness of Breath
__ Poor Circulation
__ Heart Problems
__ Heart Murmur
__ Strokes
__ Swelling Ankles
__ Varicose Veins
__ Tightness in chest

ENDOCRINE
__ Cold intolerance
__ Heat intolerance
__ Increased Appetite
__ Increased Hunger
__ Increased Thirst
__ Increased Urination
__ Hair Loss
__ Unusual hair growth
__Voice Change

HEMATOLOGIC
__ Anemic
__ Bleed Easily
__ Bruise Easily
__ Lymph Node Swelling
__ Blood Transfusion

EYES
__Blindness
__Blurred vision
__ Cataracts
__ Change in vision
__ Double vision
__ Eye pain
__Glaucoma
__Tearing
__Glasses/contacts

EAR/NOSE/THROAT
__ Dentures
__ Difficulty swallowing
__ Earache
__ Ringing in ears
__ Hearing loss
__ Loss of Smell
__ Enlarged Thyroid
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Sinus infections
__ Sore Throats
__ Tonsillitis
__TMJ

GASTRO-INTESTINAL
__ Belching/Gas
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Abdominal Pain
__ Vomiting
__ Vomiting Blood

PSYCHOLOGICAL
__ Anxiety
__ Behavioral Change
__ Bipolar
__ Depressed
__ Insomnia
__ Mood Changes

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm
__Wheezing
__ Tightness in chest

GENITO-URINARY (MALE)
__ Blood in Urine
__ Frequent Urination
__ Difficulty Urinating
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control
__ Erectile Dysfunction

SKIN OR ALLERGIES
__ Change in skin color
__ Change in nail shape
__ Hair growth / loss
__ Hives
__ Itching
__ Sensitive Skin
__ Skin Lesion
__ **Allergy** _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y / N

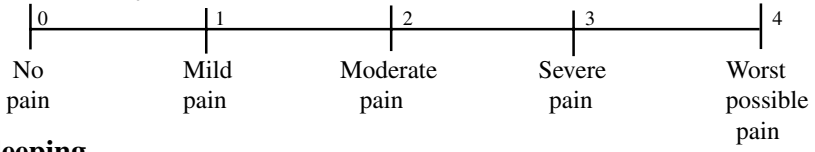
I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Functional Rating Index

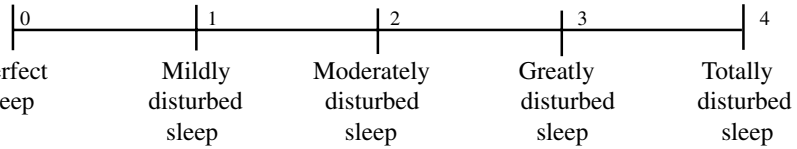
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

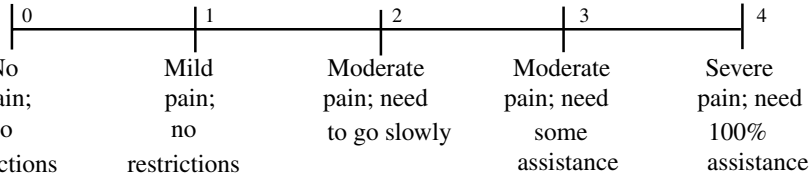
1. Pain Intensity



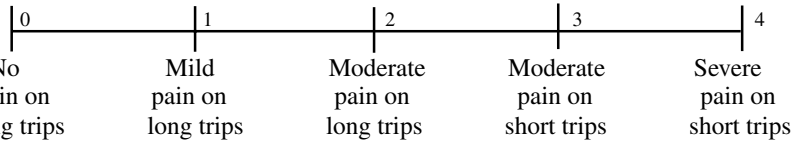
2. Sleeping



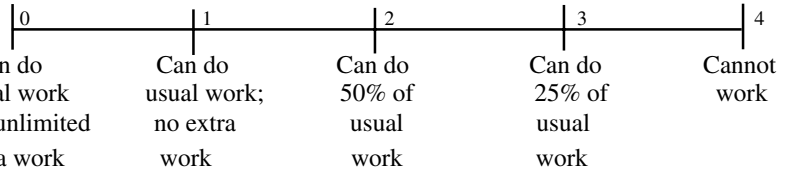
3. Personal Care (washing, dressing, etc.)



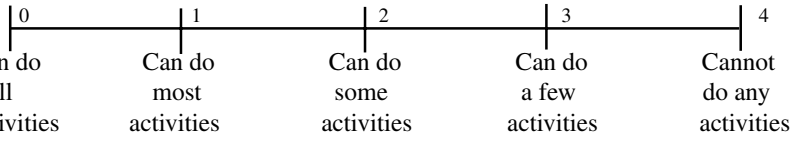
4. Travel (driving, etc.)



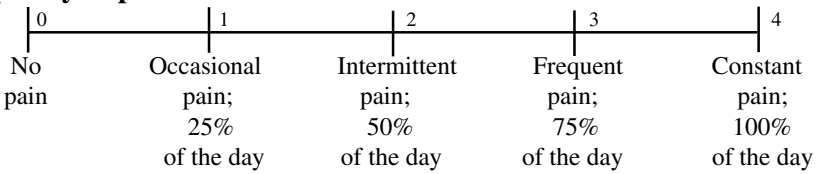
5. Work



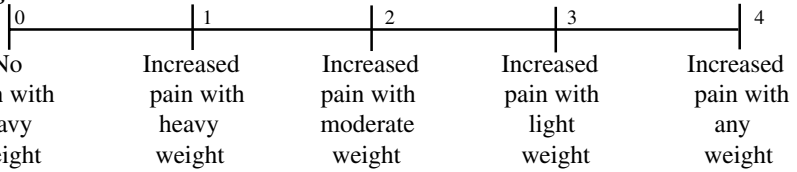
6. Recreation



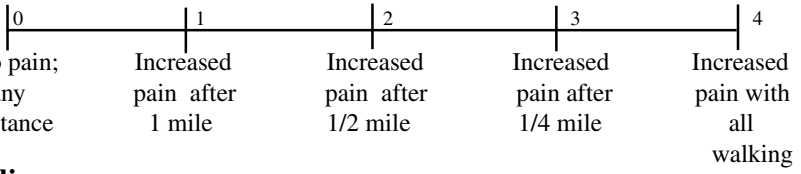
7. Frequency of pain



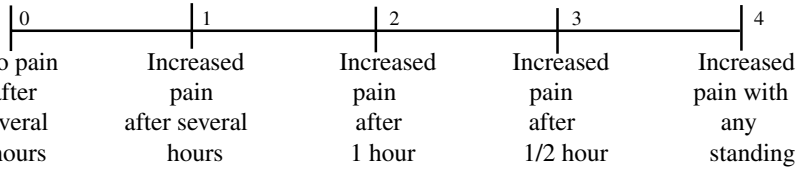
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Acknowledgment of Receipt of Notice of Privacy Practices for Protected Health Information

I acknowledge that I have received Notice of Privacy Practices for Protected Health Information from Smith Health and Wellness Clinic.

Date _____

Patient Name _____
Print Name

_____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgment

- ❏ I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy practices for protected health information by (check all that apply):
- ❏ Showing the patient the Notice of Privacy Practices posting in our office.
- ❏ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ❏ Giving the patient to sign this Acknowledgment form.
- ❏ Other (explain in detail) _____

_____

_____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):

- ❏ The patient refused to sign this form.
- ❏ The patient would not sign the form because the patient said/he/she did not understand the Notice.
- ❏ Other (explain in detail) _____

Date: _____ Name: _____

Notes: This written Acknowledgment must be completed no later than the first date health care services or treatment are provided to the patient after April 14, 2003. This Acknowledgment must be retained in the patient's permanent records.