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:_____

Description of Health

Please provide us with a description of your health history as well as your chief complaints. What are your goals for this visit and for your care in our office?

Allergies

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Complaints and Concerns

If you could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger a change in your health? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe problem	Prior treatment/approach

MEDICAL CONDITIONS

DISEASES/DIAGNOSIS/CONDITIONS

GASTROINTESTINAL ☐ Irritable Bowel Syndrome ☐ Inflammatory Bowel Disease ☐ Chrohn's ☐ Ulcerative Colitis ☐ Gastritis or Peptic Ulcer Disease ☐ Celiac Disease ☐ Other	GENITAL AND URINARY SYSTEMS ☐ Kidney Stones ☐ Gout ☐ Interstitial Cystitis ☐ Frequent Urinary Tract Infections ☐ Frequent Yeast Infections ☐ Erectile Dysfunction or Sexual Dysfunction ☐ Other
CARDIOVASCULAR ☐ Heart Attack ☐ Other Heart Disease ☐ Stroke ☐ Elevated Cholesterol ☐ Arrythmia (irregular heartbeat) ☐ Hypertension (high blood pressure ☐ Rheumatic Fever ☐ Mitral Valve Prolapse	RESPIRATORY DISEASES ☐ Asthma ☐ Chronic Sinusitis ☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea ☐ Other
METABOLIC/ENDOCRINE ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Hypoglycemia ☐ Metabolic Syndrome ☐ Insulin Resistance/Pre-Diabetes ☐ Hypothyroidism (low thyroid) ☐ Hyperthyroidism (overactive thyroid) ☐ Endocrine Problems ☐ Polycystic Ovarian Syndrome (PCOS) ☐ Infertility ☐ Weight Gain ☐ Weight Loss ☐ Frequent Weigh Fluctuations ☐ Bulimia ☐ Anorexia ☐ Binge Eating Disorder ☐ Night Eating Syndrome ☐ Other	INFLAMMATORY/AUTOIMMUNE ☐ Chronic Fatigue Syndrome ☐ Autoimmune Disease ☐ Rheumatoid Arthritis ☐ Lupus SLE ☐ Immune Deficiency Disease ☐ Herpes-Genital ☐ Severe Infectious Disease ☐ Poor Immune Function ☐ Food Allergies ☐ Environmental Allergies ☐ Multiple Chemical Sensitivities ☐ Latex Allergies ☐ Other
CANCER ☐ Lung cancer ☐ Breast cancer ☐ Colon cancer ☐ Ovarian cancer ☐ Prostate cancer ☐ Skin cancer ☐ Other	SKIN DISEASES ☐ Eczema ☐ Psoriasis ☐ Acne ☐ Melanoma ☐ Skin cancer ☐ Other
MUSCULOSKELETAL PAIN ☐ Osteoarthritis ☐ Fibromyalgia ☐ Chronic Pain ☐ Other	

SURGERIES *(include date if applicable)*

☐ Appendectomy _____
☐ Hysterectomy (+ or – ovaries) _____
☐ Gall Bladder _____
☐ Hernia _____
☐ Tonsillectomy _____
☐ Dental Surgery _____
☐ Joint Replacement: Knee / Hip _____
_____
☐ Heart Surgery – Bypass Valve _____
☐ Angioplasty or Stent _____
☐ Pacemaker _____
☐ Other _____
☐ None _____

MEDICAL HISTORY

NEUROLOGIC/MOOD
☐ Depression _____
☐ Anxiety _____
☐ Bipolar Disorder _____
☐ Schizophrenia _____
☐ Headaches _____
☐ Migraines _____
☐ ADD/ADHD _____
☐ Autism _____
☐ Mild Cognitive Impairment _____
☐ Memory Problems _____
☐ Parkinson's Disease _____
☐ Multiple Sclerosis _____
☐ ALS _____
☐ Seizures _____
☐ Other neurological problems _____

INJURIES

☐ Back injury _____
☐ Neck injury _____
☐ Head injury _____
☐ Broken bones _____
☐ Other _____

PREVENTIVE TESTS/LAST TEST DATE

☐ Full Physical Exam _____
☐ Bone Density _____
☐ Colonoscopy _____
☐ Cardiac Stress Test _____
☐ EBT Heart Scan _____
☐ EKG _____
☐ Hemoccult Test – stool test for blood
_____
☐ MRI _____
☐ CT SCAN _____

BLOOD TYPE
☐ A
☐ B
☐ AB
☐ O
☐ RH+
☐ Unknown

HOSPITALIZATIONS *(date/reason)*
_____
_____
_____
_____
_____
_____

WOMEN'S HISTORY

☐Pregnancies _____ ☐Caesarean _____ ☐Vaginal birth _____
☐Living children _____ ☐Post-Partum Depression ☐ Toxemia
☐Abortion _____ ☐Gestational Diabetes ☐ Baby over 8 lbs
☐Breast Feeding _____
(for how long)

Menstrual History

Age at first period _____ Menses Frequency _____ Length _____
Pain ☐yes ☐no Clotting ☐ yes ☐ no
Has your period ever skipped? ☐ yes ☐no Last menstrual period _____
For how long? _____
Use of hormonal contraception such as For how long?
☐Birth control pills ☐Patch ☐Nuva Ring _____
Do you use contraception? ☐Yes ☐No
☐Condom ☐Diaphragm ☐IUD ☐Partner Vasectomy

Women's Disorders/Hormonal Imbalances

☐Fibrocystic breasts ☐Endometriosis ☐Fibroids ☐Infertility
☐Painful periods ☐Heavy periods ☐PMS

Last mammogram _____ Breast biopsy date _____
Last PAP test _____ ☐normal ☐abnormal
Last Bone Density test _____ Results ☐high ☐low ☐within range
Are you in menopause? ☐yes ☐no Age of menopause onset _____
☐Hot flashes ☐Mood swings ☐Concentration/Memory problems
☐Vaginal dryness ☐Decreased libido ☐Heavy bleeding
☐Joint pains ☐Headaches ☐Weight gain
☐Palpitations ☐Loss of control of urine
☐Hormone replacement therapy _____ (how long?)

MEN'S HISTORY

Have you had a PSA done? ☐yes ☐no
PSA Level ☐0-2 ☐2-4 ☐4-10 ☐Greater than 10
☐Prostate enlargement ☐Prostate Infection ☐Change in libido
☐Impotence ☐Difficulty obtaining erection ☐Difficulty maintaining erection
☐Nocturia (urination at night) _____ (how many times per night?)
☐Urgency/hesitancy in urinary system change
☐Loss of control of urine

MEDICATIONS

Current Medications

Medication	Dose	Frequency	Start Date	Reason for use

Previous Medications

Medication	Dose	Frequency	Start Date	Reason for use

Nutritional Supplements (vitamins, minerals, herbal and homeopathy)

Medication	Dose	Frequency	Start Date	Reason for use

Have your medications or supplements ever caused you unusual side effects or problems?
☐yes ☐no If yes, describe _____

Have you had prolonged use of NSAIDS (Advil, Aleve), Mortin or Aspirin?
☐yes ☐no

Specifically Tylenol?
☐yes ☐no

Have you had prolonged regular use of acid blocking drugs (Tagamet, Zantac, Prilosec)?
☐yes ☐no

Frequent antibiotics (more than three times per year)?
☐yes ☐no

Longterm antibiotics?
☐yes ☐no

Use of steroids (Prednisone, nasal allergy inhalers)?
☐yes ☐no

Oral contraceptives?
☐yes ☐no

FAMILY HISTORY

(please check all that apply)

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Parental Grandmother	Parental Grandfather	Other
Age (if still alive)									
Age at death									
ADHD									
ALS or other Motor Neuron Diseases									
Asthma									
Autism									
Autoimmune Diseases									
Bipolar Disease									
Breast or Ovarian Cancer									
Cancers									
Celiac Disease									
Colon Cancer									
Dementia									
Depression									
Diabetes									
Eczema/Psoriasis									
Environmental Sensitivities									
Food Allergies or Intolerances									
Genetic Disorders									
Heart Disease									
Hypertension									
Inflammatory Arthritis									
Inflammatory Bowel Disease									
Irritable Bowel Syndrome									
Multiple Sclerosis									
Obesity									
Parkinson's									
Psychiatric Disorders									
Schizophrenia									
Stroke									
Substance Abuse									

SOCIAL HISTORY

Nutrition History

Have you ever had a nutrition consultant? ☐yes ☐no
Have you ever made changes to your diet due to your health? ☐yes ☐no
If yes, describe:

_____

_____

Do you currently follow a special diet or nutritional program? ☐yes ☐no _____

(please check all that apply):

☐Low fat ☐Low carbohydrate ☐High protein ☐Low sodium
☐Diabetic ☐No dairy ☐No wheat ☐Gluten restricted

Height (feet/inches) _____ Current weight _____
Usual weight range _____ Desired weight range _____
Highest adult weight _____ Lowest adult weight _____
Weight fluctuations greater than 10 lb? Body fat % _____
☐yes ☐no
How often do you weigh yourself? ☐daily ☐weekly ☐monthly ☐never
Have you ever had your metabolism checked? ☐yes ☐no
If yes, what was the resting metabolic rate? _____

Do you avoid any particular foods? ☐yes ☐no
If yes, what foods and why?

_____

_____

If you could eat only a few foods a week, what would they be?

_____

_____

Do you grocery shop? ☐yes ☐no If no, who does?_____
Do you read food labels? ☐yes ☐no
Do you cook? ☐yes ☐no If no, who does? _____
How many times do you eat out per week? ☐0-1 ☐2-3 ☐4-5 ☐more than 5

Check any factors that apply to your lifestyle and eating habits:

Fast/slow eater	Erratic eating pattern	Eating too much	Late night eating
Dislike of healthy food	Time constraints	Eating out too much	Travel frequently
Lack of healthy foods available	Not planning meals or menus ahead	Lack of understanding nutritional importance	Poor snack choices available/chosen
Family member(s) dislike healthy foods	Family member has special dietary needs	Emotional eater (when sad, lonely, depressed)	Negative relationship with food
Overuse of convenience foods	Eating too much when stressed	Eating too little when stressed	Struggle with eating issues

Do you smoke? ☐yes ☐no If yes, how much? _____
Do you drink? ☐yes ☐no If yes, how much? _____