1. In general, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
2.Compared to a year ago, my health is:	__ Excellent	__ Very Good	__ Good	__ Fair	__ Poor
3.Decrease of social activities during the past 4 weeks:	__ Not at all	__ Slightly	__ Moderately	__ Quite a bit	__ Extremely

4. Check ALL that apply to you:

General:	__ Fatigue	__ Weakness	__ Fever / Chills	__ Weight Change	__ Night Sweats
Skin:	__ Pain	__ Rash	__ Redness	__ Itching	__ Eczema
Eyes:	__ Pain	__ Discharge	__ Infection	__ Vision Trouble	
Ears:	__ Pain	__ Discharge	__ Infection	__ Hearing Trouble	__ Ringing
Nose:	__ Pain	__ Bleeding	__ Infection	__ Absence of smell	__ Obstruction
Mouth/Throat:	__ Pain	__ Bleeding	__ Gum Disease	__ Abnormal Taste	__ Lesions
Heart:	__ Pain	__ Palpitations	__ Edema/ Swelling	__ Murmur	__ Fainting
Lungs:	__ Pain	__ Cough	__ Phlegm	__ Difficult breathing	__ Bloody Discharge
Gastrointestinal:	__ Pain	__ Nausea	__ Diarrhea	__ Constipation	__ Weight Change
Genitourinary:	__ Pain	__ Discharge	__ Blood in Urine	__ Incontinence	__ Frequent Urination
	__ Sterility	__ Impotence	__ Abnormal Bleeding	__ Amenorrhea	
Endocrine	__ Hair Loss	__ Thirsty	__ Tremors	__ Hot/cold intolerance	__ Sleep issues
Neurological:	__ Headaches	__ Seizures	__ Dizziness	__ Numbness	

5. **Height:** _____ **Weight:**_____lbs **Blood Pressure:** _____/_____

APPLICATION FOR TREATMENT

6.Please check the type of care desired: ☐ **Temporary Relief** ☐ **Lasting Correction**

7. Are you interested in improving your overall health? ☐ Yes ☐ **No**

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I clearly understand and agree that all services rendered me and charged to me are my responsibility to be paid to the doctor. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

SIGNATURE REQUIRED

8.PATIENT'S SIGNATURE _____ **DATE** _____

GUARDIAN'S SIGNATURE _____ **DATE** _____

PLEASE REVIEW AND MAKE SURE ALL PAGES ARE COMPLETELY FILLED OUT.

Have you seen another doctor for your CURRENT condition(s)? ___ No ___ Yes When_____

Have you had previous tests or studies for your CURRENT condition(s)? ___ No ___ Yes When_____

Have you had previous medications or care for your CURRENT condition(s)? ___ No ___ Yes When_____

Have you lost time from work due to this CURRENT problem? ___ No ___ Yes When_____

Have you had SIMILAR symptoms in the past? ___ No ___ Yes When_____

Have you had Chiropractic care before? ___ No ___ Yes When_____

To your knowledge, are you pregnant? ___ No ___ Yes

Are you taking birth control medicines? ___ No ___ Yes

Are you seeing an OB-GYN doctor regularly? ___ No ___ Yes Name_____

CHECK ALL THAT APPLY

Your History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ AIDS/HIV	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Dizziness	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Mental Disorder	__ Insomnia	__ Digestion Issues
	__ Osteoporosis	__ Seasonal allergies	__ Alcoholism	__ Anemia	__ Asthma
Parents' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems
Siblings' History:	__ Cancer/Tumors	__ Infection/Fever	__ Heart/Cardiovascular	__ Anemia	__ Arthritis
	__ Stroke	__ Neuro Disorders/MS	__ Auto Immune Diseases	__ Osteoporosis	__ Thyroid Disease
	__ Diabetes	__ Blood Pressure	__ Dizziness	__ Insomnia	__ Digestion Problems

Current Medications:	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**	**Rx Name & Dosage Strength**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please Check the appropriate box(s):

Your Social History: __ Never **Smoked** __ **Former Smoker** __ **Current Smoker**
__ No **Alcohol** __ **Drink Alcohol** __ **No Recreational Drugs**

Allergies: __ Sinus /Respiratory __ Food / Digestion ___Medication
List OTC/Prescription Medicine that you are allergic to:_____

Surgeries/Hospitalized: Type/area_____Surgeon_____When?_____

Type/area_____Surgeon_____When?_____

Type/area_____Surgeon_____When?_____

Smith Family Chiropractic

NEW PATIENT
CONFIDENTIAL HEALTH INFORMATION

Name (Last)_____ (First)_____ (Middle)_____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital S . M. D . W Sex M. F SS #_____ Spouse's Name _____

Home # (___) _____ Work # (___) _____ Cell # (___) _____ E Mail _____

Patient's Employer _____ Your Job _____

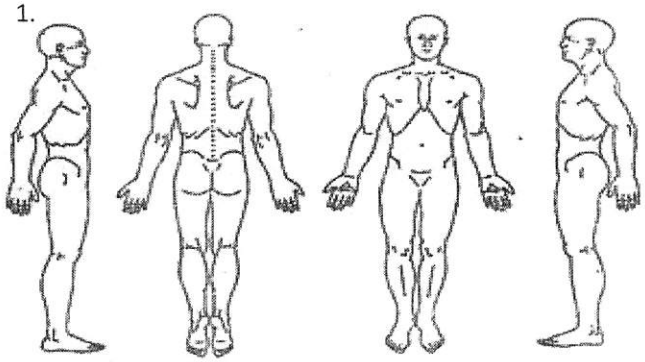
Address _____ Work # (___) _____

Insurance Co. _____ Group# _____ ID # _____

Name of Insured _____ Birth Date _____ SS# _____

Insured's Employer _____ Work # (___) _____

1.



Please outline and shade where you have pain or other symptoms

2. When did your symptoms start? _____

3. How did your symptoms begin? _____

1. PRIMARY condition:
(Choose ONLY ONE)

___ Head	___L ___R	Shoulder
___ Neck	___L ___R	Elbow
___ Upper Back	___L ___R	Arm/Hand
___ Mid Back	___L ___R	Hip
___ Lower Back	___L ___R	Knee
___ Pelvis	___L ___R	Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often?	(% of the day):
___ Constant	(76-100%)
___ Recurring	(51-75%)
___ Intermittent	(26-50%)
___ Occasional	(0-25%)

Describe Your Symptoms:

___ Sharp	___ Shooting
___ Dull	___ Burning
___ Numbness	___ Tingling

What makes your symptoms worse?

___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?

___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :

___ Morning ___ Afternoon __ Evening

2. SECONDARY condition:
(Choose ONLY ONE)

___ Head	___L ___R	Shoulder
___ Neck	___L ___R	Elbow
___ Upper Back	___L ___R	Arm/Hand
___ Mid Back	___L ___R	Hip
___ Lower Back	___L ___R	Knee
___ Pelvis	___L ___R	Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often?	(% of the day):
___ Constant	(76-100%)
___ Recurring	(51-75%)
___ Intermittent	(26-50%)
___ Occasional	(0-25%)

Describe Your Symptoms:

___ Sharp	___ Shooting
___ Dull	___ Burning
___ Numbness	___ Tingling

What makes your symptoms worse?

___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?

___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :

___ Morning ___ Afternoon __ Evening

3. ADDITIONAL conditions:

___ Head	___L ___R	Shoulder
___ Neck	___L ___R	Elbow
___ Upper Back	___L ___R	Arm/Hand
___ Mid Back	___L ___R	Hip
___ Lower Back	___L ___R	Knee
___ Pelvis	___L ___R	Leg/Foot

Please circle current pain level:

0 1 2 3 4 5 6 7 8 9 10

How Often?	(% of the day):
___ Constant	(76-100%)
___ Recurring	(51-75%)
___ Intermittent	(26-50%)
___ Occasional	(0-25%)

Describe Your Symptoms:

___ Sharp	___ Shooting
___ Dull	___ Burning
___ Numbness	___ Tingling

What makes your symptoms worse?

___ Standing ___ Walking ___ Sitting
___ Lying ___ Coughing ___ Lifting

What makes your symptoms better?

___ Resting ___ Ice ___ Heat
___ Activity ___ Medicine _____

Condition feels better in the :

___ Morning ___ Afternoon __ Evening