SMITH CHIROPRACTIC
HEALTH CARE

PATIENT HEALTH RECORD

Name: ____ Date of Birth: ______/______/______Age: _________

Address: ____ City, Zip: ________________________________

Home Phone: _________________________________ Cell Phone: ___________________________________

Work Phone: _____________________________________ Email: ___________________________________

Occupation: ____________________________________ Females: Are you pregnant? □ Yes □ No

Marital Status: □ S □ M □ W □ D Spouse Name: _________________ Spouse Occupation:___________________

Is this visit the result of a work or auto injury? □ Yes □ No If so, which one? □ Auto □ Work Injury

REASON FOR THIS VISIT

* Describe the reason for this visit: ____

* How did this condition begin? ____

* When did this condition begin? ____

* What makes it better? (rest, ice, heat, positioning, etc) ____

* What makes it worse? (sitting, standing, walking, bending, lifting, etc) ______________________________

* Does the pain:

□ Stays in one spot □ Travel to other areas

*Type of Pain:

□ Sharp/Shooting □ Ache □ Pins/Needles

□ Burning □ Numbness □ Mild □ Other

*In the past week on average how often have your symptoms been present?

(Intermittent) □ 0-25% □ 26-50% □ 51-75% □ 76-100% (Constant)

* In the past week how often has your pain interfered with your daily activities [eg, work, social activities or household chores?]

0 1 2 3 4 5 6 7 8 9 10

No Interference **Unable to carry on activities**

* Please rate your pain (10 being worst)

1 2 3 4 5 6 7 8 9 10

* Has this condition occurred before? □ Yes □ No Please Explain: ____________________________________

* Have you ever seen doctors for this condition? □ Yes □ No

Type of Doctor: ____________________________ Type of Treatment: ___________________________________

Did it help? □ Yes □ No □ Temporary Relief

Any other recent health concerns? ____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ____________________________

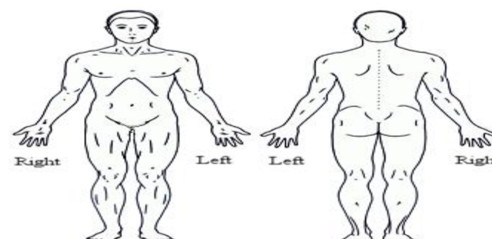
Have you been adjusted by a Chiropractor before? □ Yes □ No

Reason for those visits? ____________________________________

Doctor's Name: ____

Approximate date of last visit? ______________________________

Mark the location of your pain.



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HEALTH CONDITIONS

Please check each of the diseases or conditions you have now or have had in the past.

□ Headache	□ Dizziness	□ Neck Pain	□ Head Seems Too Heavy
□ Feet Cold	□ Neck Stiff	□ Pins and Needles in Arms	□ Numbness in Fingers/Toes
□ Ears Ring	□ Hands Cold	□ Sleeping Problems	□ Pins and Needles in Legs
□ Back Pain	□ Buzzing in Ears	□ Constipation	□ Nervousness
□ Loss of Balance	□ Cold Sweats	□ Tension/Irritability	□ Shortness of Breath
□ Fainting	□ Fatigue	□ Chest Pain	□ Depression

Family History: □ Cancer □Diabetes □ Arthritis □ Cardiovascular Disease

Do you smoke? □ Never □ Past □ Present □ Occasionally □ Daily

Does this problem bother you enough that you would like to come here for treatments to get rid of your discomfort? □ YES □ NO

AUTHORIZATION AND RELEASE

AUTHORIZATION OF TREATMENT: I give my consent and authorization to Smith Chiropractic Health Care to use, and/or disclose my protected health information (PHI), for the purpose of providing necessary treatment to me; in obtaining payment for such treatment and to carry out its health care operations. I also understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Futhermore, I understand that this office will offer assistance with any claim forms needed from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am ultimately responsible for payment. 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. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I hereby authorize the doctor to treat my condition as he deems appropriate through the use of adjustments throughout my spine.

HIPPAA STATEMENT: I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

INFORMED CONSENT TO TREATMENT When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent confusion and disappointment. Adjustment: An adjustment is for the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments to the spine. Health: A state of optimal physical, mental and social well-being, not merely the absence of disease: The purpose of chiropractic services is to promote health through the release of maximum nervous energy. Since there are so many variables, it is difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes the results are phenomenal. In some cases, there are more gradual responses, occasionally the results are mediocre or dismal. Many people find results with chiropractic care in turn we must admit that conditions which do not respond chiropractically may come under the control of medical science. We will do our very best in determining that you need chiropractic care, however we cannot be held responsible for a medical diagnosis, or under Illinois Trial Law be responsible for a medical referral.We do not offer diagnosis or treat any disease of condition other than vertebral subluxation, however, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider that specialize in that area. In remote instances, chiropractic manipulative treatment has aggravated disc conditions and cardiovascular conditions. Literature shows this to be very infrequent, but can happen. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustments to correct vertebral subluxation.

Patient or Guardian Signature: ____ Date: ____________________