File # __________

SMITH FAMILY CHIROPRACTIC
PATIENT INFORMATION AND HISTORY

Date: ________________

PATIENT INFORMATION

Name: ______________________________________
Address: ____________________________________
City: _______________________________________
Postal Code: _________________________________
Date of Birth: ______________________ Age: _____
Male ___ Female ___ Sex at birth: _____________
Preferred Pronouns: ___________________________
Home / Cell Phone: ___________________________
Work Phone: _________________________________
Email: ______________________________________
How did you hear about the clinic? ______________
____
Occupation: __________________________________
Employer: ___________________________________
Parent's Name (if minor): _______________________
Single__Married__Divorced__Widowed__Partnered_
Spouse / Partner's Name: _______________________
# of Children: ____ Name(s): ____________________
IN CASE OF EMERGENCY, PLEASE CONTACT:
Name: ______________________________________
Relationship: _________________________________
Phone #: ____________________________________

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name: ________________________
Group ID/Policy Number: _________________________
Member Number: _______________________________
Relationship to Cardholder: _______________________
Name of Cardholder: ____________________________

ACCOUNT INFORMATION

Is your condition due to an accident? Yes No Date: ______
Type of accident? Auto __ Work __ Home __ Other _____

Prior Chiropractic care? Yes __ No __
Doctor's Name: ________________________________
Date of last treatment? __________________________
X-Rays taken? Yes __ No __ Date: ___________________
Results of care? Excellent __ Good __ Fair __ Poor __
Medical Doctor's Name: __________________________
Medical Doctor's Location: ________________________
Date of last appointment: _________________________
Date of last physical: ____________________________

PATIENT CONDITION

Primary complaint(s): ____
When did this condition begin? _________________ Was the condition the result of an accident or injury? Yes __ No __
Please describe the cause of the current complaint: ____
Have you had this problem before? Yes __ No __ If yes, when: __________
How often do you feel it? Constant __ Daily __ Comes and goes __
How does it feel? (*circle all that apply*)

Sharp Stabbing Aches Throbbing Shooting Burning

Dull Sore Weak Numbness Gripping Tingling Other: _______

Does the pain spread to other areas? _____________________
Circle below the severity of your pain on a scale of 0 to 10:

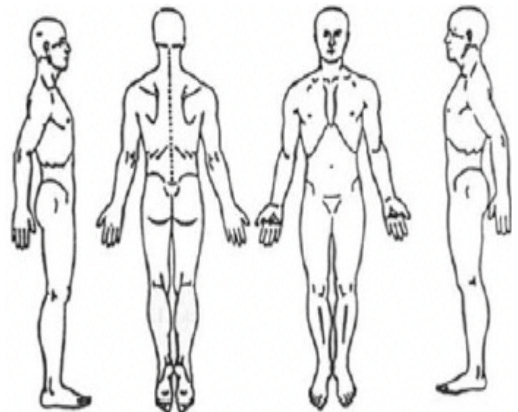
(No pain) 1 2 3 4 5 6 7 8 9 10 (Severe pain)

What makes your condition better? _____________________
What makes your condition worse? _____________________
Activities/movements that are painful/difficult to perform:

Sitting Standing Walking Bending Lying down Driving Other: __________

Does it interfere with your: Work __ Sleep __ Daily Routine __ Recreation __
What other treatment have you had for this condition?
Chiropractic __ Medical __ Physical Therapy __ Surgery __ Other: ________
Is there anything else you would like the doctor to know about this condition? ______________________________

Please mark where it hurts



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What are your top 3 health goals?

1. ____
2. ____
3. ____

Is there anything else you would like the doctor to know? ______________________________
____

PERSONAL HEALTH HISTORY

Please read the following lists for conditions or problems you have had. Your answers will help detect areas or systems associated with your overall course of care.

Check any of the following disorders you have had in the past. Circle those you are currently experiencing.

Musculoskeletal:
( ) Low back pain
( ) Pain between shoulders
( ) Heartburn
( ) Neck pain
( ) Arm pain/leg pain
( ) Colitis
( ) Joint pain/stiffness
( ) Walking problems
( ) Difficulty chewing
( ) Jaw clicking
( ) General stiffness
( ) Bursitis
( ) Foot trouble

Nervous System:
( ) Numbness
( ) Paralysis
( ) Dizziness
( ) Forgetfulness
( ) Confusion/depression
( ) Fainting
( ) Convulsions
( ) Cold/tingling arm or leg
( ) Stress
( ) Allergies
( ) Chills
( ) Headaches
( ) Headaches – Migraine
( ) Loss of sleep
( ) Sweats
( ) Tremors

Cardiovascular & Respiratory:
( ) Chest pain
( ) Shortness of breath
( ) Blood pressure problems
( ) Irregular heartbeat
( ) Heart problems
( ) Lung problems
( ) Congestion
( ) Varicose veins
( ) Ankle swelling
( ) Stroke
( ) Hardening of arteries
( ) Poor circulation
( ) Chronic cough
( ) Spitting blood
( ) Wheezing/asthma
( ) Fever
( ) Fatigue

Ears, Eyes, Nose & Throat:
( ) Vision problems
( ) Dental problems
( ) Sore throat
( ) Ear aches
( ) Hearing difficulty
( ) Stuffed nose
( ) Ringing in the ear
( ) Sinus infections
( ) Smell changes
( ) Taste changes
( ) Speaking problems

Gastrointestinal:
( ) Digestive issues
( ) Gas/Bloating after meals
( ) Black/bloody stool
( ) Food Sensitivities
( ) Weight gain
( ) Weight loss

Skin:
( ) Boils
( ) Bruise easily
( ) Dryness
( ) Hive or allergy
( ) Itching
( ) Rashes
( ) Acne

Genito-Urinary:

Do you have any Genito-Urinary issues?
____
____
____

Males:
( ) Prostate/sexual dysfunction

Females:
( ) Menstrual irregularity
( ) Menstrual cramping/pain
( ) Vaginal pain/infections
( ) Breast pain/lumps

When was your last period?
____

Are you pregnant or is there a possibility you are pregnant?
( ) Yes ( ) No ( ) Not Sure

File # __________

Stressors:

( ) Smoking Packs/day: __________
( ) Coffee Cups/day: ___________
( ) Alcohol Drinks/week: ________
( ) High stress level Reason: ________________________________

Exercise:

( ) None ( ) Moderate ( ) Daily ( ) Heavy

Sleep:

How many hours of sleep do you get each night?
Do you wake up feeling rested? ( ) Yes ( ) No
Do you have difficulty falling asleep? ( ) Yes ( ) No
Do you have difficulty staying asleep? ( ) Yes ( ) No

Medications/Supplements:

List any medications you are taking:

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Vitamins/herbs/minerals:

___________________________________ ___________________________________
___________________________________ ___________________________________
___________________________________ ___________________________________

Have you had any:	**Description**	**Date**
Automobile/work related accidents:		
Surgeries:		
Broken Bones:		
Falls/Head injuries:		
Were you ever unconscious?		
Illness or system problems:		
Recent Colds, Flu, Illness, or Diseases		

Are your complaints affecting your ability to work or be otherwise active?

( ) No effect.
( ) Some physical restrictions (able to perform work and light tasks).
( ) Need limited assistance with common everyday tasks.
( ) Need assistance often.
( ) Have significant inability to function without assistance.
( ) Totally disabled/impaired. Cannot care for self.

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CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with chiropractic, massage, soft tissue and other related services, Smith Family Chiropractic will collect some personal information about me as outlined in the Confidential Patient Health Record.

I understand that I may at any time request a copy of Smith Family Chiropractic's Privacy Policy, which outlines the use and disclosure of personal information and steps taken to protect this information.

I hereby give Smith Family Chiropractic permission to contact me regarding appointments, special occasions or events, and information updates. I also understand that Smith Family Chiropractic may at times be required to share personal information with other health care professionals following the guidelines as set out in their Privacy Policy.

_______________________________________ Patient's Name

_______________________________________ Signature

_______________________________________ Date

_______________________________________ Witness

File # __________

FEE SCHEDULE
PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Consultation	$30.00
Initial Assessment/ Examination	$90.00
Report of Findings	$55.00
Each Treatment	$55.00
Acupuncture	$50.00

Senior

Initial Assessment/ Examination	$80.00
Each Treatment	$46.00
Acupuncture	$50.00

Student

Initial Assessment/ Examination	$80.00
Each Treatment	$40.00

Children 0-12 Years

Initial Assessment/ Examination	$60.00
Child	$35.00
Pre-School	$27.00

Soft Tissue Therapy

Acupuncture	$50.00
Supportive Myofascial Therapy	$16.00
Ultrasound	$16.00
Trigger Points	$20.00
Emergency (out of hours)	$65.00

X-ray Viewing:

Out of Office	$25.00
In Office	$20.00

Laser Therapy

1 point	$17.50
2 points	$ 26.25
3 points	$ 35.00
4 points	$ 45.00
5 minute points	$ 20.00

Massage

30 minute	$67.80
45 minute	$84.75
60 minute	$98.31
90 minute	$146.90

I hereby understand the aforementioned information and agree to pay any and all amounts for services as they are rendered.

Signature ____________________ Date ____________________