CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Smith Chiropractic LLC
Dr. Terry C. Smith D.C.
1825 Main St – Unit C
Colorado Springs, CO 80911
719-390-5404
Website: www.DrTerrySmith.com
email: info@drterrysmith.com

ABOUT YOU

Today's Date: _____/_____/_____ File #:_____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____ ☐Male ☐ Female

Birthdate: _____/_____/_____ Age: _____ SS#_____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Cell Phone #:_____

E-Mail Address: _____

How did you hear about us? _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How Many? _____

INSURANCE INFO

***Please allow our staff to photocopy your insurance card(s)**

Insurance Company Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #:_____ Insured's SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____ Date of Birth: _____/_____/_____

Insured's Employer:_____

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

Who is your Medical Doctor?_____

Phone #:_____

REASON FOR VISIT

The symptom(s) that have prompted me to seek care today include:_____

And are the result of: ☐ An accident or injury: ☐ Work ☐ Auto ☐ Other_____

☐ A worsening long-term problem ☐ An interest in: ☐ Wellness ☐ Other_____

Onset (When did you first notice your current symptoms?)**:**_____

Quality of symptoms (How does it feel?):

☐ Numbness ☐ Tingling ☐ Stiffness
☐ Dull ☐ Aching ☐ Cramps
☐ Nagging ☐ Sharp ☐ Burning
☐ Shooting ☐ Throbbing ☐ Stabbing
☐ Other_____

How does you current condition interfere with :

Work:_____

Recreation:_____

Home:_____

Relationships:_____

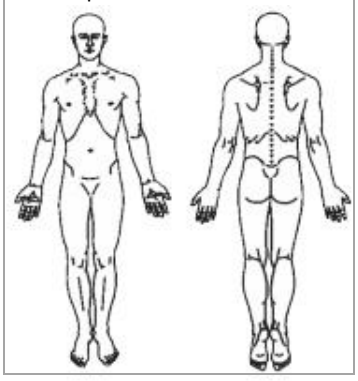
Sleep:_____

Other:_____

Intensity (How extreme are your current symptoms?)**:**

0 o-o-o-o-o-o-o-o-o-o-o **10**
Absent Uncomfortable Agonizing

Location (Where does it hurt?)
Circle the area(s)
"0" for current conditions
"X" for past conditions



Duration and Timing (When did it start and how often do you feel it?):

☐ Constant ☐ Comes and goes. How often? _____

Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?)**:**

_____

Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, activities, etc)**:**

Worsens problem(s):_____

Lessens problem(s):_____

Prior interventions (What have you done to relieve the symptoms?)

☐Prescription medication ☐Surgery ☐Ice
☐Over-the-counter drugs ☐Acupuncture ☐Heat
☐Homeopathic remedies ☐Chiropractic ☐Other____
☐Physical therapy ☐Massage _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below, other licensed doctors of chiropractic, or other staff members who now or in the future work at the office listed below or any other associated office. _____ (initials)

I understand and am informed that, as in the practice of medicine, the chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. There are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. It is my responsibility to make known any conditions that might not come to the attention of the doctor. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic and I understand that results are not guaranteed. _____ __ (initials)

Chiropractic is a science, philosophy and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) relative to range of motion, muscular and neurological aspects, as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease, pain or infirmity. I understand that the chiropractor will use his hands or mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". _____ (initials)

Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. If during the course of care, we encounter non-chiropractic or unusual finding, we will advise you of those findings and recommend that you seek the services of another health care provider. _____ (initials)

I understand that my consent need only be obtained one time for my present condition and any future condition (s) for which I may seek treatment. I also understand that I can revoke this consent at any time in writing for all future procedures. I also understand that any video or photographic material I may appear in, may be used for documentation and for any way this office sees fit to further research and awareness. If I decline to sign this consent this office has the right to refuse to render care. _____ (initials)

I have read, or have had read to me, this Informed Consent for Chiropractic Care. I have had the opportunity to ask questions about its content, and have had my questions explained to my satisfaction in a way that I can understand. By voluntarily signing below I agree to the above named procedures regarding my care in this office and am authorizing them to proceed with any treatment they may deem necessary in my case. _____ (initials)

PREGNANCY RELEASE: This is to certify that to the best of my knowledge, I am not pregnant and the above doctor (and associates) has my permission to perform and x-ray evaluation if deemed necessary. I have been advised that x-ray can be hazardous to an unborn child.
Date of last Menstrual Cycle: _____ Initials: _____

_____	_____	_____	_____
Name (printed)	DOB	Signature	Date

Patient Information Form

Due to HIPAA regulations, our office is required to obtain additional information not presented on our New Patient form. Please take a moment to complete the following.
Thank you.

Name: _____ **Birth date:** _____

☐ Male ☐ Female **Preferred Language:** _____

Race:_____ **Height:** _____

☐ Hispanic ☐ Non Hispanic ☐ Unspecified **Weight:** _____

Do you smoke? ☐ Yes ☐ No

Allergies

Medical: _____

Other: _____

Current Medications: ☐ None

_____

_____

_____

_____

_____

Office use only

Blood Pressure: _____ / _____

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Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy

NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms

NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness

NONE ○ Initials ____

Doctor's Initials

Smith Chiropractic LLC
Dr. Terry C. Smith D.C.

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter): _____

Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

Family History

Some health issues are hereditary. Tell Dr. Smith about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

Are there any other hereditary health issues that you know about? _____

Social History

Tell Dr. Smith about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?		Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?		Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much?		Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?		Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?		Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?		Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much?				

Hobbies: _____

Doctor's Initials

Smith Chiropractic LLC

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

What is the major stressor in your life? _____ **How much sleep do you average per night?** _____ **Hours**

What is the type and approximate age of your mattress and pillow? _____ **What is your preferred sleeping position?** _____

Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

What would be the most significant thing that you could do to improve your health? _____

In addition to the main reason for your visit today, what additional health goals do you have? _____

Patient name

Patient Number
(office use only)

Notes