SMITHFIELD CHIROPRACTIC

Date_____

Name_____ **Preferred Name**_____

Address_____**City**_____ **State** _____ **Zip** _____

Cell Phone _____ **Home Phone**_____ **SSN** _____

Primary Email _____ **Gender at Birth** ❑ Male ❑ Female

Date of Birth _____ **Marital Status** ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Other

Emergency Contact _____ **Contact Phone** _____

How did you hear about our office? _____

Have you had previous chiropractic care? ❑ Yes ❑ No If Yes, when was your last adjustment? _____

Employment Status ❑ Employed ❑ Self Employed ❑ Retired ❑ Student ❑ Other

Occupation_____ **Employer**_____

Do you have health insurance? ❑ Yes ❑ No **Insurance Name** _____

Primary insured? ❑ Yes ❑ No **If no, primary insured name and relationship to self** _____

Family Physician _____ **Practice Name**_____

Medications **No current medications check here: ❑** **Attach list if necessary**	**Allergies (medications, foods, or environment)** **No known allergies check here: ❑** **Attach list if necessary**
1)	1)
2)	2)
3)	3)
4)	4)

FAMILY HISTORY: Please mark all conditions you **(S=Self)** or your family members **(F=Family)** have had

S F	S F	S F	S F
❑ ❑ Alcoholism	❑ ❑ Diabetes	❑ ❑ High cholesterol	❑ ❑ Osteoporosis
❑ ❑ Anemia	❑ ❑ Drug abuse	❑ ❑ HIV/Immune disease	❑ ❑ Stroke
❑ ❑ Arthritis	❑ ❑ Epilepsy/Seizures	❑ ❑ Kidney disease	❑ ❑ Thyroid disease
❑ ❑ Asthma	❑ ❑ Fibromyalgia	❑ ❑ Liver disease	❑ ❑ Tuberculosis
❑ ❑ Cancer	❑ ❑ Hepatitis	❑ ❑ Lung disease	❑ ❑ Ulcers
❑ ❑ Depression	❑ ❑ High blood pressure	❑ ❑ Mental illness	❑ ❑ Other: _____

Health History

Any surgeries or hospitalizations: (date and type): ❑ None_____

Auto accidents or work injuries (date and type): ❑ None_____

Social History

Do you drink alcohol? ❑ Yes ❑ No **Do you smoke?** ❑ Yes ❑ No **Do you use any recreational drugs?** ❑ Yes ❑ No

Please mark all of the symptoms that you are CURRENTLY experiencing. Leave blank if NA

General
❑Fatigue
❑Fever
❑Weight gain
❑Weight loss

Skin
❑Eczema
❑Lesions
❑Psoriasis
❑Rashes
❑Redness

HEENT
❑Congestion
❑Ear pain
❑Eye pain
❑Eye redness
❑Headaches
❑Hearing changes
❑Itchy eyes
❑Jaw pain
❑Runny nose
❑Sore throat
❑Vision changes
❑Watery eyes

Respiratory
❑Cough
❑Shortness of breath
❑Wheezing

Cardiovascular
❑Calf pain
❑Chest pain
❑Fainting
❑Palpitations
❑Swollen ankles/feet

GI
❑Abdominal pain
❑Bloating
❑Blood in stool
❑Constipation
❑Diarrhea
❑Indigestion
❑Nausea
❑Vomiting

GU
❑Blood in urine
❑Flank pain
❑Incontinence
❑Painful urination

MSK
❑Back pain
❑Joint pain
❑Neck pain
❑Swelling
❑Weakness

Neuro
❑Dizziness
❑Memory loss
❑Numbness
❑Tingling
❑Tremors

Psych
❑Anxiety
❑Depression
❑Suicidal thoughts

Heme/Lymph
❑Easy bleeding
❑Easy bruising
❑Swollen glands in neck

Endocrine
❑Excessive hunger
❑Excessive thirst
❑Frequent urination
❑Hair/Skin/Nail changes
❑Heat/Cold intolerance

Allergy
❑Environmental allergies
❑Food allergies
❑Food intolerance

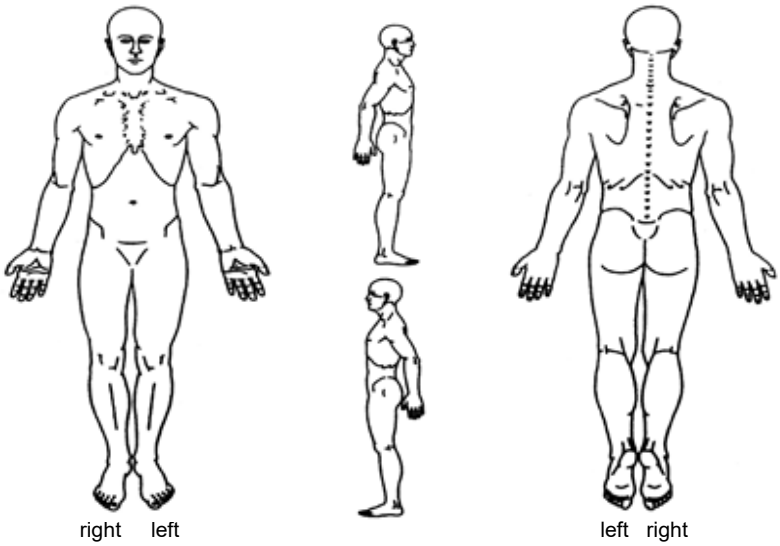
Women Only
Are you pregnant?
❑Yes
Due date: _____
❑No
❑Ovarian cysts/fibroids
❑Painful/Irregular periods

Please list in ORDER OF SEVERITY any pain, health problems, symptoms, and/or complaints you are experiencing.

1. _____ for how long? _____
2. _____ for how long? _____
3. _____ for how long? _____
4. _____ for how long? _____

On the diagram below, please circle areas of pain and indicate using the following letters:

A: ache **B:** burning **C:** cramping **D:** dull **N:** numbness **R:** throbbing **S:** sharp **T**: tingling



On the scale below, please circle the Severity of your Main Complaint at its Worst:

Mild				*Moderate*					*Severe*
1	2	3	4	5	6	7	8	9	10

On the scale below please circle the Percentage of Time you experience your Main Complaint:

	Occasional			*Intermittent*		*Frequent*		*Constant*		
0	10	20	30	40	50	60	70	80	90	100