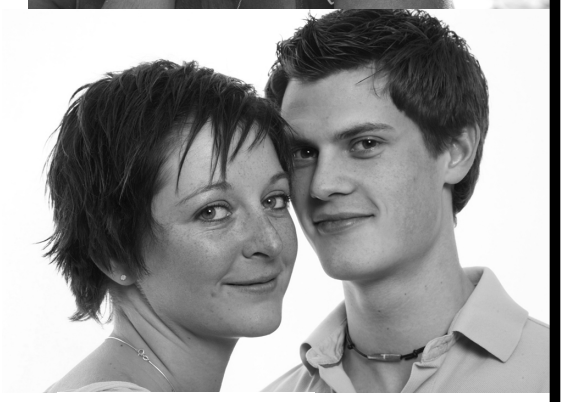
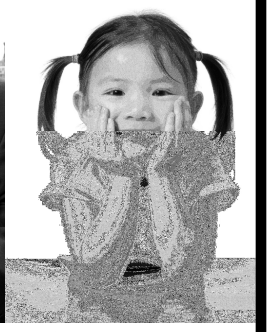
WELCOME TO SMITH FAMILY CHIROPRACTIC

For the

New Patient

OUTLINE OF PROCEDURES FOR CARE





STEP ONE:
All patients are requested to fill out all pages of this personal health history.

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:
The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:
You will given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP SIX:
An estimate of the future care that is needed will be given and upon your acceptance, care will begin.

STEP SEVEN:
Care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

PERSONAL HISTORY

Name:_____ Sex: ❑Male ❑Female

Address: _____ City:_____

State:_____ Zip:_____

Home Phone:_____ Birth Date:_____

Cell Phone:_____ Age:_____

Social Security #:_____ Driver's License #:_____

Business Employer:_____ Business Phone:_____

Type of Work:_____ Email:_____

Circle One: Married Single Widowed Divorced Separated Name of Spouse:_____

Names and Ages of Children:_____

Referred To This Office By:_____

Name and Number of Emergency Contact:_____

Who is Responsible for Your Bill, You and ❑Spouse ❑Workers' Comp. ❑Auto Insurance ❑Medicare ❑Medicaid

Personal Health Insurance Name:_____

CURRENT HEALTH CONDITION

Unwanted Health Condition:_____

Other Doctors Seen For This Condition: ❑Yes ❑No Who?_____

Type of Treatment:_____ Results:_____

When Did This Condition Begin?_____ Has This Condition Occurred Before? ❑Yes ❑No

Is Condition: ❑Job Related ❑Auto Accident ❑Home Injury ❑Fall ❑Other:_____

Date of Accident:_____ Time of Accident:_____

Have You Made A Report of Your Accident to Your Employer: ❑Yes ❑No

Drugs You Now Take: ❑Nerve Pills ❑Pain Killers/Muscle Relaxers ❑Blood Pressure Medicine ❑Insulin

❑Other:_____

Do You Wear a Shoe Lift? ❑Yes ❑No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?_____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ❑ Appendectomy ❑Tonsillectomy ❑Gall Bladder ❑Hernia ❑Back Surgery

❑Broken Bones ❑ Other:_____

Major Accidents or Falls:_____

_____

Hospitalization (Other Than Above):_____

_____

Previous Chiropractic Care: ❑Yes ❑No Doctor's Name & Approximate Date of Last Visit_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

❑Pneumonia	❑Mumps	❑Influenza	
❑Rheumatic Fever	❑Small Pox	❑Pleurisy	**INTAKE:**
❑Polio	❑Chicken Pox	❑Arthritis	❑Coffee
❑Tuberculosis	❑Diabetes	❑Epilepsy	❑Tea
❑Whooping Cough	❑Cancer	❑Mental Disorders	❑Alcohol
❑Anemia	❑Heart Disease	❑Lumbago	❑Cigarettes
❑Measles	❑Thyroid	❑Eczema	❑White Sugar

Have you been tested HIV positive? ❑Yes ❑No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
- ❑Low Back Pain
- ❑Pain Between Shoulders
- ❑Neck Pain
- ❑Arm Pain
- ❑Joint Pain/Stiffness
- ❑Walking Problems
- ❑Difficult Chewing/Clicking Jaw
- ❑General Stiffness
- ❑Gas/Bloating After Meals

NERVOUS SYSTEM CODE
- ❑Nervous
- ❑Numbness
- ❑Paralysis
- ❑Dizziness
- ❑Forgetfulness
- ❑Confusion/Depression
- ❑Fainting
- ❑Convulsions
- ❑Cold/Tingling Extremities
- ❑Stress

GENERAL CODE
- ❑Fatigue
- ❑Allergies
- ❑Loss of Sleep
- ❑Fever
- ❑Headaches

GASTRO-INTESTINAL CODE
- ❑Poor/Excessive Appetite
- ❑Excessive Thirst
- ❑Frequent Nausea
- ❑Vomiting
- ❑Diarrhea
- ❑Constipation
- ❑Hemorrhoids
- ❑Liver Problems
- ❑Gall Bladder Problems
- ❑Weight Trouble
- ❑Abdominal Cramps

- ❑Colitis
- ❑Heartburn
- ❑Black/Bloody Stool

GENITO-URINARY CODE
- ❑Painful/Excessive Urination
- ❑Discolored Urine
- ❑Bladder Trouble

C-V-R CODE
- ❑Chest Pain
- ❑Short Breath
- ❑Blood Pressure Problems
- ❑Irregular Heartbeat
- ❑Heart Problems
- ❑Lung Problems/Congestion
- ❑Varicose Veins
- ❑Ankle Swelling
- ❑Stroke

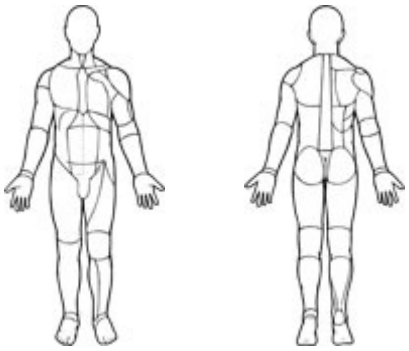
EENT CODE
- ❑Vision Problems
- ❑Dental Problems
- ❑Sore Throat
- ❑Ear Aches
- ❑Hearing Difficulty
- ❑Stuffed Nose

MALE/FEMALE CODE
- ❑Menstrual Irregularity
- ❑Menstrual Cramps
- ❑Vaginal Pain/Infection
- ❑Breast Lumps/Pain
- ❑Prostate/Sexual Dysfunction
- ❑Other Problems
- ❑_____
- ❑_____
- ❑_____

FEMALES ONLY

When was your last period?_____

Are you pregnant?
❑Yes ❑No ❑Not Sure



Please outline on the diagram your areas of discomfort.

FAMILY HISTORY

The following members have a same or similar problem as I do:
- ❑Mother
- ❑Father
- ❑Brother
- ❑Sister
- ❑Spouse
- ❑Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:
DIAGONOSIS:
Patient Accepted: ❑Yes ❑No ❑Referred

_____
Doctor's Signature

Most patients that come into our office have one or two objectives in mind concerning their health care. Some patients come for the symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑Relief Care ❑Corrective Care ❑Check here if you want the Doctor to select the type of care appropriate for your condition.

_____ _____

Date Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!

Relief Care
Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet because of a leak but not fixing the leak.

Corrective Care
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I understand and agree that health and accident insurance policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Smith Family Chiropractic 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 upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he/she deems appropriate. It is understood and agreed that the amount paid to the Doctor for x-rays is for the examination only and the x-rays negatives will remain the property of this office, being on file where they may be seen at any time when a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature_____Date_____

Consent to Treat a Minor_____Date_____

Guardian or Spouse's Signature
of Authorizing Care_____Date_____