SMYRNA CHIROPRACTIC

Confidential Patient Questionnaire

Today's Date: _____/_____/_____

Name: ____ ____Male ____Female

What You Prefer To Be Called: ____

Date of Birth: ____/____/____ Social Security Number: _____________________________________

Marital Status: ____ Single ____ Married ____ Divorced ____Widowed

Home Address: ____ Apt. #________

City____State___________________Zip_________________

Home Phone Number: ______________________________ Cell/Mobile: __________________________

Email address: ____

Employer: ___________________________________ Occupation: _______________________________

Employer Address: ____

Employer Phone Number: ____

Primary Health Care Physician: ______________________________ Phone: ________________________

How did you hear about Smyrna Chiropractic? ____

REASON FOR VISIT

Reason for today's visit: ____

Is this condition related to: ____ Auto Accident ____Slip/Fall Accident ____Work

If so please explain: ____

Date this condition began: ____/____/____ Is this condition worse? ____ Yes ____ No

Is this condition: ____constant ____comes and goes

Is this condition interfering with: ____Work ____Sleep ____ Daily Routine

If so please explain: ____

Have you had this or similar conditions in the past? ____Yes ____No

What makes your condition worse? ____

What makes your condition better? ____

How would you rate your pain today on a scale of 1 to 10? ____

How would you rate your average pain this past week on a scale of 1 to 10? __________

Have you ever received chiropractic care in the past? ____ Yes ____ No

Was the treatment effective? ____ Yes ____ No

Who treated you? ______________________________________ When? ____/____/____

Have you seen a medical physician for this condition? ____ Yes ____ No

Who treated you? ______________________________________ When? ____/____/____

HEALTH HISTORY

Have you suffered from (please mark C for Currently, P for Past):

___C ___P Headaches
___C ___ P Neck Pain
___C ___P Joint Stiffness
___C ___P Arm Pain
___C ___P Tingling/Arms
___C ___P Numbness/Arms
___C ___P Leg Pain
___C ___P Tingling/Legs
___C ___P Numbness/Legs
___C ___P Cold/Hand Feet
___C ___P Diabetes/Tuberculosis
___C ___P Arthritis
___C ___P Hip Pain
___C ___P Shoulder Pain
___C ___P Artificial Bones/Joints
___C ___P Upper Back Pain
___C ___P Lower Back Pain
___C ___P Loss of Smell
___C ___P Sinus/Allergy
___C ___P Asthma/Emphysema
___C ___P Ulcers/Colitis
___C ___P Heart Attack/Stroke
___C ___P Heart Defect
___C ___P Pacemaker
___C ___P Cancer
___C ___P Chemotherapy
___C ___P H/L Blood Pressure
___C ___P Shingles
___C ___P Kidney Problems
___C ___P Painful Urination
___C ___P Dizziness/Fainting/Seizures/ Epilepsy
___C ___P Shortness of Breath
___C ___P Chest Pain
___C ___P Psychiatric Problems
___C ___P Alcohol/Drug Abuse
___C ___P HIV+/Aids

Please list any other serious medical condition(s) you have or ever had: ______________________________

____

Please list any medication that you are currently taking: ____

Please list any past serious accidents with dates: ____

Emergency Contact: ____________________________________ Relation: ______________________________

Phone Number: ____ Other: ________________________________

For Women: Are you taking Birth Control? ___Yes ___ No Are you pregnant? ___Yes ___No

- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.**

Patient Signature: ____ Date: ___/___/____

***If Patient is a minor, we would need the Parent or Guardian's signature.**