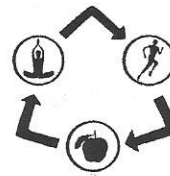


General Patient Intake Form



Smith Chiropractic
2875 Holme Avenue
Philadelphia, PA 19152
215-673-1113

Patient Information:

Full Name _____ Nickname: _____ Date: _____
Email _____ Gender M F DOB _____ HT ' " WT _____ lbs.
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell phone (____) _____ Work phone (____) _____
Marital Status: S M D W # of children _____ Social Security # _____
Employer _____ Occupation _____ Work Status: FT PT Retired
Employer Address _____ City _____ ST _____ Zip _____
Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____
Spouse's Employer _____ Spouse's Occupation _____ Wk Phone _____
Emergency Contact _____ Relationship _____ Phone _____
How did you hear about our office? _____

Insurance Information:

Insurance Carrier _____ Primary Insured _____
Insured's Date of Birth _____ Insurance Policy ID _____ Group # _____
Relationship to Patient Self Spouse Parent Other Patient is Full time student Part time student
Is the condition related to Auto Injury Work Injury Other Injury
Do you have secondary insurance coverage Y N Insurance Company Name _____
Insured's Name _____ Insured's Date of Birth _____ SS# _____
Policy ID _____ Group Number _____ Phone (____) _____

Patient Health History:

ALLERGIES: *Please check and list all allergies*

Food _____
 Medications _____
 Seasonal / Other _____

MEDICATIONS: *Please list all medications that you are currently taking* _____

SUPPLEMENTS: *Do you take Vitamins or Herbs?* Y N Who recommended them? _____

List supplements/herbs that you take _____

HABITS: Heavy Moderate Light None

Alcohol	_____	_____	_____	_____	Exercise	_____	5-7x/wk	_____	3-5x/wk	_____	1-3/xwk	_____	None		
Coffee	_____	_____	_____	_____	Sleep	_____	8+ hrs	_____	7-8 hrs	_____	6-7 hrs	_____	< 5 hrs		
Soda	_____	_____	_____	_____	Meals / Day	_____	5+	_____	4	_____	3	_____	2	_____	1
Tobacco	_____	_____	_____	_____	Stress Level	_____	High	_____	Moderate	_____	Low	_____	What Stress		
Drugs	_____	_____	_____	_____	Water / day	_____	64+ oz	_____	23-63 oz	_____	16-32 oz	_____	<8 oz		
Work Activity:	_____	Heavy Labor	_____	Light Labor	_____	Mostly Sitting	_____	Mostly Standing	_____	Walking/ Moving					

Current Condition:

Complaint/Problem: _____

When did you first notice this problem? List date when first occurred _____

How did it originally occur? _____ Has it changed recently? ___ Y ___ N ___ Same ___ Better ___ Worse

Has another doctor(s) treated you for this condition ___ Y ___ N If yes, when _____

Previous Treatment _____

Have you had any intolerance or reactions to treatments? ___ Y ___ N Describe: _____

How frequent is the condition? ___ Constant ___ Daily ___ Intermittent ___ Night only ___ Activity Induced

How long does it last? ___ Constant ___ Few hours ___ Few Minutes

Is this condition interfering with your ___ Work ___ Sleep ___ Daily routine ___ Recreation

How long has it been since you really felt good? ___ Days ___ Weeks ___ Months ___ Years ___ >10 years

Describe the pain: ___ Sharp ___ Dull ___ Numb ___ Tingling ___ Aching ___ Burning ___ Stabbing

What makes the problem worse? ___ Standing ___ Sitting ___ Lying ___ Bending ___ Lifting ___ Twisting

Is there anything that you can do to relieve the problem? ___ Y ___ N If yes, describe _____

If no, what have you tried to do that has not helped? _____

Are there any other conditions or symptoms that may be related to your major symptom? ___ Y ___ N

If yes, what? _____

Have you ever been in an auto accident? ___ Past year ___ Past 5 years ___ Over 5 years ___ Never

Describe _____

Please mark all of the symptoms that apply with a P or C (P = Past / C=Current)

___ Tingling ___ Nausea ___ Weak Muscles ___ Dizziness ___ Excessive Thirst ___ Frequent Urination
___ Insomnia ___ Sinusitis ___ Constipation ___ Sore Muscles ___ Teeth Grinding ___ Low Back Pain
___ Fatigue ___ Neck Pain ___ Blurred Vision ___ Facial Pain ___ Carpal Tunnel ___ Jaw Problems
___ Earache ___ Hip Pain ___ Joint Stiffness ___ Shoulder Pain ___ Elbow/Hand Pain ___ Tension
___ Headache ___ Knee Pain ___ Swollen Joints ___ Ankle/Foot Pain ___ Abdominal Pain ___ Memory Loss
___ Fainting ___ Eye Pain ___ Tingling in Feet ___ Other: _____

Family History: Identify any conditions that you, or any of your family members have or had in the past:

(G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

___ Alcoholism	___ Eczema	___ Miscarriage(s)	___ Tumor(s)
___ Anemia	___ Emphysema	___ Mumps	___ Ulcer(s)
___ Asthma	___ Epilepsy	___ Pleurisy	___ Other: _____
___ Cancer	___ Heart Disease	___ Stroke	_____
___ Chemotherapy	___ HIV/AIDS	___ Psychiatric Problems	
___ Cold Sores	___ Headaches	___ Rheumatic Fever	
___ Diabetes	___ Sinus Problems	___ High/Low Blood Pressure	

Patient Signature _____ Date _____