Thomas G. Smith, D.C.

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire in full. It will become part of your permanent record.

Name _____ Date of Birth ____/____/____ □ Female □ Male

Street Address _____City _____State _____Zip _____

Phone #s: Home (____) _____Work (____) _____Cell (____)_____

E-mail_____ □ I would like to receive e-newsletters and e-mail specials.

Marital Status: □ M □ S □ D □ W Spouse's Name _____ # of Children _____Ages_____

Occupation _____ Employer _____

How did you hear about us? _____If referred, by whom? _____

What is your major health complaint? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? □ Yes □ No

Do any positions make it feel worse? □ No □ Yes Explain _____

Do any positions make it feel better? □ No □ Yes Explain _____

Is this condition: □ Improved □ Unchanged □ Getting Worse?

Is this condition interfering with your: □ Work □ Sleep □ Daily Routine □ Other ? _____

Name other doctors or therapists who have treated this condition _____

List surgical operations and dates _____

_____

List medications _____

List current supplements _____

Emergency Contact Name: _____ Relationship _____ Contact phone # _____

Family Physician Name _____Phone # _____

Street Address _____City _____State ____Zip _____

Have you been in an auto accident or had any other personal injury? □ No □ Yes - Describe _____

_____

_____

Patient Signature _____Date _____/_____/_____

Parent or Guardian Signature _____Date _____/_____/_____

REVIEW OF SYSTEMS

Name _____ Date_____

GENERAL
- ▢ Recurring Fever
- ▢ Recent weight loss or gain
- ▢ Dizziness
- ▢ Fever
- ▢ Chills

HEENT
- ▢ Headaches or migraines
- ▢ Eye or vision problems
- ▢ Eyeglasses or contact lenses
- ▢ Nose bleeds
- ▢ Eye surgery
- ▢ Cataracts
- ▢ Glaucoma
- ▢ Sore throat
- ▢ Hoarseness
- ▢ Swollen glands
- ▢ Nose congestion or sinus trouble
- ▢ Ear or hearing problems
- ▢ Dental problems
- ▢ Gum problems
- ▢ TMJ problems
- ▢ Postnasal drip

SKIN / HAIR
- ▢ Skin trouble or rashes
- ▢ Flushing
- ▢ Excessive acne
- ▢ Eczema
- ▢ Psoriasis
- ▢ Skin cancer
- ▢ Skin pigmentation issues
- ▢ Change in hair or nails
- ▢ Blood in stool
- ▢ Easy bruising
- ▢ Gum bleeding

CARDIOVASCULAR
- ▢ Chest pain or tightness
- ▢ Heart attack
- ▢ Shortness of breath
- ▢ Palpitations
- ▢ Swelling of feet or hands
- ▢ High blood pressure
- ▢ Low blood pressure
- ▢ High cholesterol or triglycerides
- ▢ Blood clots
- ▢ Pacemaker
- ▢ Mitral valve prolapse
- ▢ Congenital heart defects
- ▢ Rheumatic fever
- ▢ Leg pain upon walking
- ▢ Varicose veins
- ▢ Dizziness
- ▢ Excessive bruising
- ▢ Coronary artery disease

RESPIRATORY
- ▢ Persistent cough
- ▢ Spitting up blood
- ▢ Asthma or wheezing
- ▢ Shortness of breath
- ▢ Exercise intolerance
- ▢ Sleep apnea
- ▢ Emphysema
- ▢ Snoring issues
- ▢ Tuberculosis
- ▢ Pneumonia
- ▢ Breathing or lung problems
- ▢ Hay fever

GASTROINTESTINAL
- ▢ Loss of appetite
- ▢ Nausea or vomiting
- ▢ Diarrhea
- ▢ Constipation
- ▢ Abdominal pain
- ▢ Stomach ulcer
- ▢ Bloating/Cramping
- ▢ Heartburn
- ▢ Hemorrhoids
- ▢ Hepatitis
- ▢ Cirrhosis
- ▢ Difficulty swallowing
- ▢ Jaundice
- ▢ Liver disease
- ▢ Gallbladder problems
- ▢ Pancreatitis
- ▢ Change in bowel habits
- ▢ Black or bloody stool
- ▢ Colon cancer or polyps
- ▢ Food sensitivities
- ▢ Irritable bowel syndrome
- ▢ Crohn's disease
- ▢ Gastric reflux
- ▢ Colitis

NEUROLOGICAL
- ▢ Frequent headaches
- ▢ Migraines
- ▢ Dizziness
- ▢ Fainting
- ▢ Memory loss
- ▢ Poor balance
- ▢ Numbness or tingling
- ▢ Pins and needles
- ▢ Epilepsy or seizures
- ▢ Stroke
- ▢ Tremors
- ▢ Head injury
- ▢ Anxiety and/or panic
- ▢ Depression
- ▢ Sleeping issues
- ▢ Weak muscles
- ▢ Loss of smell or taste
- ▢ Temporary loss of vision
- ▢ Difficulty concentrating

MUSCULOSKELETAL
- ▢ Arthritis
- ▢ Joint pain or swelling
- ▢ Neck pain
- ▢ Back pain
- ▢ Trauma
- ▢ Osteoporosis
- ▢ Scoliosis
- ▢ Cramping
- ▢ Fractures
- ▢ Implants, plates, pins or screws
- ▢ Hip disorders
- ▢ Knee injuries
- ▢ Foot / ankle pain
- ▢ Shoulder problems
- ▢ Elbow / wrist pain
- ▢ Poor posture
- ▢ Gout

REVIEW OF SYSTEMS, pg. 2

Name _____ Date _____

BLOOD / LYMPH
- ▢ Anemia
- ▢ Bleeding
- ▢ Bruising
- ▢ Blood clots
- ▢ Past transfusions
- ▢ Leukemia
- ▢ Lymphoma
- ▢ HIV/AIDS
- ▢ Sickle cell

ALLERGIES
- ▢ Seasonal
- ▢ Medication
- ▢ Food

PSYCHIATRIC
- ▢ Alzheimer's Disease
- ▢ Insomnia
- ▢ Difficulty concentrating
- ▢ Memory loss/confusion
- ▢ Depression
- ▢ Anxiety
- ▢ Agitation/Irritability
- ▢ Suicidal thoughts
- ▢ Chemical dependency

ENDOCRINE
- ▢ Diabetes
- ▢ Thyroid problems
- ▢ Sweating
- ▢ Heat intolerant
- ▢ Cold intolerant
- ▢ Weight loss
- ▢ Weight gain
- ▢ Frequent urination
- ▢ Excessive thirst
- ▢ Change in appetite
- ▢ Hair changes
- ▢ Hyperthyroidism
- ▢ Hormonal or glandular concerns
- ▢ Hyperparathyroidism
- ▢ Testosterone deficiency
- ▢ Cushing's syndrome
- ▢ Steroid treatments

URINARY
- ▢ Painful or frequent urination
- ▢ Incontinence
- ▢ Hesitancy
- ▢ Urgency
- ▢ Blood in urine
- ▢ Kidney stones
- ▢ Urinary infections
- ▢ Genital or bladder or urinary complaints

MALE
- ▢ Dribbling
- ▢ Loss of libido
- ▢ Erectile dysfunction
- ▢ Sexually transmitted disease
- ▢ Testicular pain or lumps
- ▢ Prostate disease
- ▢ Penile discharge

FEMALE
- ▢ Painful sex
- ▢ Vaginal discharge
- ▢ Breast pain or lumps
- ▢ Hot flashes
- ▢ Menstrual irregularity
- ▢ Loss of libido
- ▢ Menopause
- ▢ Sexually transmitted disease

SOCIAL HISTORY

Current weight:_____ Height _____

Have you recently lost or gained weight? ▢ No ▢ Yes If yes, how much? _____

Mental work: ▢ Heavy ▢ Moderate ▢ Light Hours per day _____

Physical work: ▢ Heavy ▢ Moderate ▢ Light Hours per day _____

Exercise: ▢ Heavy ▢ Moderate ▢ Light Hours per day_____ Days per week _____

Smoking: ▢ Currently smoke ▢ Smoked in past Packs per Day _____ # of years _____

Alcohol: Drinks per week _____

Caffeine (coffee, tea, cola): Cups? _____ Drinks per day _____

Aspirin: # per day _____

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PATIENT CURRENT COMPLAINT

Patient Name _____

Please check all boxes that apply to your condition and fill in the spaces that describe your present complaint(s). The information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaint(s) and total health picture.

Please list your present complaint(s) and mark your level of pain today, for each complaint. If you have more than one area of complaint, list them in order of most severe to least severe. Circle one for each complaint.

1. _____ Duration (How long) _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

2. _____ Duration (How long) _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

3. _____ Duration (How long) _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

Were you treated for these episodes? ☐ No ☐ Yes - If yes, by whom? _____

How did your symptoms begin?

☐Immediately after a incident ☐After multiple incidents ☐Gradually developed over time ☐Other_____

What makes your symptoms better?

☐ Nothing ☐Lying down ☐ Standing ☐Sitting ☐Movement/Exercise ☐ Other _____

What makes your symptoms worse?

☐ Nothing ☐ Lying down ☐ Standing ☐ Sitting ☐ Movement/Exercise ☐ Other _____

Description of pain or symptoms:

☐ Sharp ☐ Shooting

☐ Dull ☐ Burning

☐ Ache ☐ Numbness

☐ Weakness ☐ Tingling

☐ Throbbing ☐ Other_____

Does your pain move or radiate? □ No □Yes

Where: _____

Check the best and worse times of day for your pain:

Worse	**Best**
☐ First Awake	☐ First Awake
☐ Morning	☐ Morning
☐ Afternoon	☐ Afternoon
☐ Evening	☐ Evening
☐ Night time	☐ Night time
☐ Other _____	☐ Other _____

Frequency of pain or symptoms:

Constant (75-100%)
Frequent (51-75%)
Occasional (26-50%)
Intermittent (25% or less)

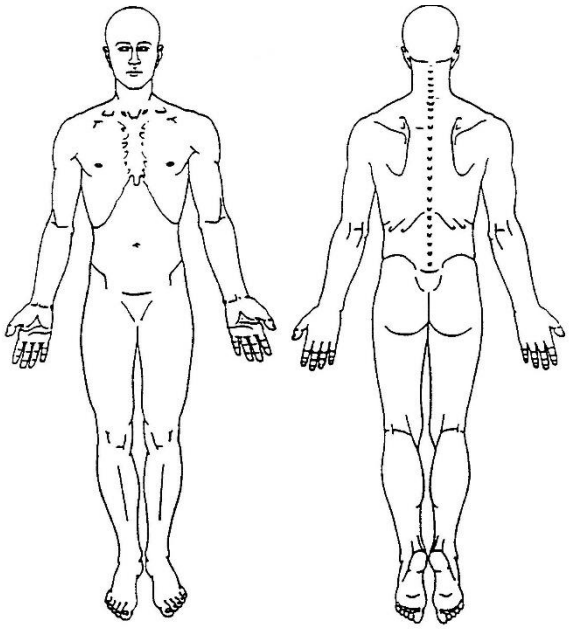
How many days out of an average week are you in pain?
(Circle one) 1 2 3 4 5 6 7

How much time during the day are you in pain? _____ hours

SHOW US YOUR PAIN

Use the letters below to indicate the type and location of your symptoms today:

C = Constant **A** = Ache **B** = Burning **N** = Numbness
P = Pins & Needles ***S*** = Stabbing **H** = Sharp
X = Stiffness **T** = Throbbing **O** = Other



Thomas G. Smith, D.C.

MISSED APPOINTMENTS POLICY

We ask for your assistance and cooperation in keeping your scheduled appointment date and time.

It is our policy that if a patient misses or cancels an appointment with less than 24 hours notice, that patient will be charged the regular office visit fee for that time. This policy is necessary to avoid the numerous schedule problems that last minute cancellations and missed appointments create!

If the need arises to cancel or change your appointment, we would appreciate 48 hours notice, when possible, but no less than 24, to avoid an unnecessary charge to you.

We thank you for your cooperation and look forward to being a vital part of your health recovery and maintenance.

I have read and understand the above policy:

Patient Signature_____ Date_____

Patient Name (Print) _____

HIPAA: CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that the Thomas G. Smith, D.C. Notice of Privacy Practices has been provided to me.

I understand my right to review the Thomas G. Smith, D.C. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treat- ment, payment of my bills, or in the performance of health care operations of CAM. This Notice of Privacy Practices also describes my rights and CAM duties with respect to my protected health information. The Notice of Privacy Practices for CAM can be provided, on request, at the front desk.

Thomas G. Smith, D.C. reserves the right to change the privacy practices described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed, or by asking for a copy at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Thomas G. Smith, D.C. has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge receipt of a copy of this notice, and my understanding, and agreement, to the terms:

Patient Signature_____ Date_____

Patient Name (Print) _____

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. I authorize you to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

2. I authorize my attorney to make direct payments to you of any sum I now, or hereafter, owe. Payment is to be taken out of the proceeds of any settlement of my case and by any insurance company obligated to make payment to myself or you based, in whole or in part, upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to myself, or to you, for the charges for chiropractic services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the pertinent data below) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that I am responsible for paying whatever amounts not collected from insurance proceeds (whether it be all or part of what is due).

INSURANCE PAYMENT AGREEMENT

Dear Patient,

Discrepancies can occur between information provided to us by your insurance company and what your insurance actually covers. Due to the unpredictable nature of insurance billing, it is possible that your insurance company may raise payment questions regarding coverage of payment.

YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED.

Most insurance companies provide literature outlining the specifics of their coverage. Please refer to this literature, or contact your insurance company directly, to answer any questions regarding your chiropractic health care coverage.

I have read and understand all of the above:

Patient Signature_____ Date_____

Patient Name (Print) _____

Thomas G. Smith, D.C.

INFORMED CONSENT

I hereby consent to the performance of examination and treatment on me by the licensed Doctor of Chiropractic, and/or therapists who may be employed or engaged in practice in this clinic.

I have an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different therapy procedures and chiropractic treatment (manipulation/adjustment}. I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgment to attempt to anticipate or explain risks and complication and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course of treatment, based upon facts known, that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care, which includes rarely, but not limited to fractures, disc injuries, strokes and strain/sprains, and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained, regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition, and for any future conditions for which I seek treatment.

Patient Signature_____ Date_____

Patient Name (Print) _____