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479-271-6993

PATIENT APPLICATION

Welcome to Smith Family Clinic! We specialize in helping patients to achieve their highest level of health through our Structural, Neurologic and Metabolic corrective care programs.

This application is extensive because we are committed to being thorough with your care. The questions we ask provide important information that will help us determine whether or not we can help you. You deserve the best, so please give us yours when you answer these questions.

Please remember to sign the last page indicating you have thoroughly completed this application and returnthisapplication at leasttwobusinessdaysprior to your scheduled appointment. This must be accomplished before your consultation. Pleasefeel free call us if you need assistance.

Thank you. We look forward to serving you.

Revised: 10/09

PATIENTAPPLICATIONSURVEY

- Ifyourequiremorespaceforanyoftheseanswers, please note with " Æ " and use the back side of this form or attach additional information. PleasecompletethisapplicationinPen.

Today's Date: ___________________

Name: Mr./Mrs./Ms. ___________________________ Address ___________________________

Apt #______City______________________State ___ Zip _________ Home Phone (   )_____________________

Work (   ) _____________ Cell (   ) ______________Best place to reach you: ❒Home ❒Work ❒Cell

If necessary, may we leave a message for you at any of the above numbers? ❒Yes ❒No

Email: ___________________________________(Additional appointment information may need to be emailed.)

Employer: ___________________Occupation (Before retirement): ____________________ Duties:_____________

Duration of Employment: ______________ Age: _____Date of Birth_____/_____/______

Sex: ❒M ❒F Martial Status: ❒S ❒M ❒W ❒I Have a 'significant other'

Name (First/Last) of Spouse / Partner / Significant Other:______________________

* I (signature) ______________________________consent to allow Dr. Smith to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for care in the Smith Family Clinic and also to determine if he is willing to accept my case. ❒If this consult/examination is for a minor over whom I have legal guardianship, I give my permission (signature):

Who referred you to our office? / How did you find out about our services? ___________________________________

What is your mainconcern/symptom(a.k.a..chiefcomplaint) prompting your request for a consultation with the doctor?

____

How long have you had this problem? _________ Did your symptoms begin suddenly? ❒Yes ❒No

Considering the amount of discomfort you've had THIS week, how long has your problem been this severe? ________

Is this problem related to an auto accident / work injury? ❒Yes ❒No If so, when & describe: _____________

____

Have you had an auto accident / or work injury in the last 7 years? ❒Yes ❒No. Do you have any accident claims currently open for any reason? ❒Yes ❒No : Describe: ____

If you can, describe any activity change, event, or accident that occurred around the time of the onset of your symptoms which may have contributed to your symptoms? (Includeanysignificantemotionallystressfulsituations.)

____

____

____

Have you had MRI's / CT scans taken?: ❒Yes ❒No Of whatpart(s) of your body ____________________

Where (what facility took them) & When ____

MRI & Report brought to our office ❒Yes ❒No (Please bring these to our office or we can help you request them.)

Previous Spine X-rays taken withinlastyear ❒Laying down ❒Standing ❒Seated ❒Neck ❒Low Back ❒Other:__________ ❒Where were they taken?______________

Women Only: Is there a possibility that you may be pregnant? ❒Yes ❒No

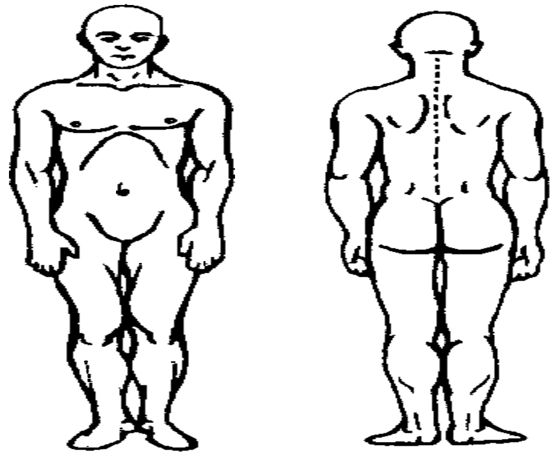
PLEASE LIST AND PRIORITIZE YOUR CURRENT AREAS OF MAIN COMPLAINT:
(#1 is your chief complaint, #2 is of secondary importance, etc.)

1) ______________________ 2) ____________________ 3) ____________________ 4) ____________________

What % of the day does yourchiefcomplaint(#1)botheryou? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= ^^^^^
Shooting	= Æ
Weakness	= W
Other________________	= ***



Please circle the appropriate number(s) for the intensity of your pain when aggravated and the letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time)
I = Intermittent (26-50%)
F = Frequent (51-75%)
C = Constant (76-100%)

Area of Pain/Issue	Normal	Minimal	Slight			Moderate			Severe			Frequency			
												25%	50%	75%	100%
Neck		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Middle Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Lower Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hips L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Shoulders L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Arms L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Legs L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Headaches		1	2	3	4	5	6	7	8	9	10	O	I	F	C
DIzziness/ Vertigo:		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10	O	I	F	C

Regarding you chief complaint, on a Scale of 0-10 (10 = unbearable, 0 = No Discomfort) Please rate the following:
The HIGHEST your pain/discomfort gets WITHOUT medication ___________ WITH Medication ________
The LOWEST your pain/discomfort gets WITHOUT medication ___________ WITH Medication ________

Questionsregardingyour ChiefComplaint:

When is it worse: ❐in the morning ❐as the day progresses ❐when I sleep ❐no specific time ❐at work

❐Other: _________

❐Increase & decrease with no apparent trigger. Details:____

Does anything relieve your pain/problem?____

What activities/movements are guaranteed to make it worse? ____________________________________

What positions are difficult? ❒Sitting ❒Standing ❒Walking ❒Bending ❒Lying Down

❒Other ____

<u>IfLowBackPain</u>: Which direction hurts more when bending? ❒Backwards ❒Forward ❒Both hurt

STRUCTURALCONDITIONS

Please list and date all memorable previous accidents and falls, even if unrelated to complaints: ____________

____

____

____

Have you been <u>diagnosed</u> with herniated / bulging disc/ or another spine condition? ❒Yes ❒No
Who Diagnosed you and when? ____
The Diagnosis was made by ❒MRI ❒CT Scan ❒X-ray ❒Other: ______________________________

Have you been advised to have surgery or injections for the above condition? ❒Yes ❒No. Details about recommendations:____

____

How interested are you in following the above recommendations for surgery / injections / etc.: ____________

Spine & Hip Surgeries

Specific Area	Date	Type (Please be specific.)	Results (to another region)
		❒Fusion Æ ❒metal installed ❒no metal ❒Laminectomy ❒Discectomy ❒	❒Improved ❒No Change ❒Worse
		❒Fusion Æ ❒metal installed ❒no metal ❒Laminectomy ❒Discectomy ❒	❒Improved ❒No Change ❒Worse
		❒Fusion Æ ❒metal installed ❒no metal ❒Laminectomy ❒Discectomy ❒	❒Improved ❒No Change ❒Worse

Additional Surgeries (anything which may have included internal scar tissue, e.g., hysterectomy, gall bladder removal, thyroid, shoulder surgery, etc.)

Area	Date	What was done (Please specific)	Results (to another region)
			❒Improved ❒No Change ❒Worse
			❒Improved ❒No Change ❒Worse
			❒Improved ❒No Change ❒Worse

History of Cancer ❒Yes ❒No

Location of Origin	Status	Spread (to another region)
	❒Active ❒Remission ❒Monitored	❒No ❒Yes, to:
	❒Active ❒Remission ❒Monitored	❒No ❒Yes, to:

<u>AdditionalRemarks</u>

Pleasecheckanyofthefollowingasapplicabletoyou.

❒Difficulty starting/stopping/ controlling/ urine flow
❒Bowel Movement Difficulty
❒Numbness around the seated area / anus
❒Diagnosed with Abdominal Aortic Aneurysm
❒Spinal Disc Space Infections
❒Osteoporosis ❒ Fractures due to osteoporosis
❒Recent Compression Fracture? Where?
❒Diagnosis of Spinal Stenosis
❒Chronic use of steroids or narcotics
❒Coughing / Sneezing / Laughing increases back / leg pain (Circle applicable)

PASTTREATMENT HISTORY

What kinds of treatments have you received for your chief complaint?

❒Surgeries (Listed previously) ❒Medications (list later in application)

Epidural: How Many _________ When ____________
Physical Therapy: How Long __________ When ____________

Chiropractic Care: ____

If so, pleasebrieflyexplainyourlikesanddislikes: ____

____

Other: ________________________________ When________________
________________________________ When ________________
________________________________ When ________________

Did any of these treatments work? If so, which one(s)? For how long?

____
____
____

Other than routine check ups, forwhatconditions have you sought medical attention and fromwhatspecialistand when? How did you respond?____

____
____
____
____
____
____

Do you blame anyone or hold anyone partially responsible for your current condition or for making your condition worse? (Be very specific) ____

____
____

Have you received other diagnostic tests? ❒Yes ❒No. Type and results: ____________________________

____
____

Have you received any BloodAnalysis/Bloodtesting within the past 18 months? ❒Yes ❒No

~ Please bring a copy of the results to your consultation. ~

CONTINUEDNARRATIVEOFCHIEFCOMPLAINT

Please provide a detailed description of events immediately preceding the development of your condition and through today. If this complaint is due to a recent auto or work accident with an open claim, please also include a description of the accident details. Additionally, you may use this space to provide additional information you feel will help us asses your case. ____

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____ (Additional Info ❐Attached ❐On Back)

HEALTH HISTORY

Do you currently have or have you previously had any of the following symptoms or conditions: (Use back if needed)

Past Present	CurrentTreatment	Past Present	CurrentTreatment
❐ ❐ Midback Pain / Stiffness		❐ ❐ Chest Pain or Pressure	
❐ ❐ Pins & Needle Sensation anywhere?		❐ ❐ Shortness of Breath	

Past Present	Current Treatment	Past Present	Current Treatment
❒ ❒ Cold hands / Feet (Circle)		❒ ❒ High Blood Pressure	
❒ ❒ Anxiety		❒ ❒ Digestive Difficulties	
❒ ❒ Depression		❒ ❒ Heartburn	
❒ ❒ Mood Swings		❒ ❒ Ulcers	
❒ ❒ Sleeping Problems		❒ ❒ Constipation	
❒ ❒ Fatigue		❒ ❒ Urinary Problems	
❒ ❒ Dizziness – Describe.		❒ ❒ Allergies	
❒ ❒ Loss of Balance		❒ ❒ Menstrual Pain	
❒ ❒ Fainting		❒ ❒Menstrual Irregularity	
❒ ❒ Increased sensitivity to light		❒ ❒Hot flashes	
❒ ❒ Ringing/ Buzzing in Ears		❒ ❒ Fever	
❒ ❒ Loss of memory		❒ ❒ (other)	
❒ ❒ Loss of smell		❒ ❒	
❒ ❒ Loss of taste		❒ ❒	

Additional Details:

Medications Currently Taking

Name	For What Condition	Name	For What Condition

HEALTH & LIFESTYLE

Check box if you: ❒Drink coffee / another source of caffeine? Amount & Frequency: ___________

❒Drink diet soda? Amount & Frequency: ______ ❒Do you smoke? Amount & Frequency: ________

❒Consume alcohol? How often? __________ ❒Use recreational drugs? Type & How often:______

❒Exercise? ❒Yes ❒No How often? _____X per week/month. What activities? ____________________

❒Take any supplements (i.e. vitamins, minerals, herbs)? What type? **(If not easily listed, please provide a list.)** ____________________

Do you have to sleep in a particular position to be comfortable? ____________________

When you wake, are you ❒refreshed ❒in more pain then when you went to bed. Describe:____________

Mattress/Bed comfort Æ ❒poor ❒fair ❒excellent Age of mattress:

Pillow comfort Æ ❒poor ❒fair ❒excellent Age of pillow:

Please write down in detail everything you eat and drink for 3 consecutive days. We want this to be your 'normal' diet!

Day 1 (Include approximate times)	Day 2	Day 3
Breakfast:		
Snacks		
Lunch		
Mid-Day		
Dinner		
Other		

Have you had recent changes to your diet or eating habits? ❒Yes ❒No Describe:______________________

____

Do you suspect you have any food allergy or intolerance? ❒Yes ❒No Describe: ______________________

____

What tests have you received to determine food sensitivities? ____

FAMILYHISTORY

Hasanyoneinyourfamilyhadthefollowing?

❒ Any immune disease such as Arthritis, Rheumatoid Arthritis, Juvenile RA, Lupus, Diabetes I or II, Hashimotos Dz or other Thyroid condition, Psoriasis or other? Who and What? (List even if unsure if it is an immune system disorder).____

____

____

____

❒ Gastrointestinal condition or food intolerance (allergies to wheat, dairy, soy, egg, etc.)? ______________

____

List any additional significant health history issues in your family:

____

____

____

____

____

LIFE IMPACT ASSESSMENT

As you answer the following questions, please do not minimize any impact on your life no matter how small it appears. We consider any loss of ability or function which affects your daily life as significant. Please check as many that apply; add additional comments in the margin or on the back as needed.

How have others been affected by your health condition? ❒No one is affected ❒Haven't noticed any problem
❒They tell me to do something ❒People avoid me ❒Other: ______________________________

What are you afraid this might be (or is beginning) to affect (or will affect) in any way? ❒Energy
❒Your mood / attitude ❒Stress ❒Job ❒Kids ❒Future ability ❒Marriage
❒Any relationships (frequency visiting, quality, etc.) ❒Self-esteem ❒Sleep ❒Time
❒Finances ❒Freedom ❒Other: ______________________________

Are there health conditions you are afraid this might turn into? ❒Family health problems
❒Heart disease ❒Diabetes ❒Arthritis ❒Fibromyalgia ❒Depression ❒Chronic Fatigue
❒Need surgery ❒Other: ______________________________

How has your health condition affected your job, relationships, finances, family, or other activities?
Please give examples: ______________________________

____

____

____

____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)
Try to give 3 examples: ______________________________

____

____

____

What are you most concerned with regarding your problem? ______________________________

____

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

____

What would be different/better without this problem? Please be specific ______________________________

____

What do you desire most to get from working with us? ______________________________

____

What is that worth to you? ______________________________

____

SELFASSESSMENT&TREATMENT GOALS

In spite of the fact that you are not a specialist, what, in your opinion, do you think the real problem is?

____

____

Would you consider this problem (check one): ❒MINIMAL (Annoying but causing NO limitations)
❒SLIGHT (Tolerable but causing a little limitation) ❒MODERATE (Sometimes tolerable but causing limitations)
❒SEVERE (Causing significant limitations and/or concern) ❒EXTREME (Causing near constant (Limits you > 80% of the time)

Whichbestdescribesyourhealthgoals:

- o Pain Relief Only (not interested in correction of the problem).
- o Would like to find the cause of this problem and have it improved or corrected.
  How strong is your desire to correct this problem ❒Mild ❒Moderate ❒High ❒Extremely High
- o Wellness / Preventative care – I just want to stay well and be at optimal health

How supportive is your Spouse/Family/Significant Other to you seeking care? (Be very specific)

____

____

____

Are you able to handle a complete investigation and management of your case? ____________________

____

What is YOUR idea of an ideal doctor? ______________________________________

____

There may be services that your insurance company does not cover. If this is the case, we have many reasonable and affordable payment options. If you have a problem that we can help, would you be willing to pay out of pocket to get better? ❒Yes ❒No

Based on your complementary consultation, history and exam findings, you may require additional tests that require payment at time of service. If this is required, youwill beinformedinadvance.

Method of payment for any additional uncovered services today: ❒Cash ❒Check ❒Credit Card

I, ______________________________(Please Print Full Name), have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. Additionally, I have read and reviewed all supportive information that has been included with my application – this may include written or recorded material. If I do not have the means to review the material, I have contacted the Chiropractic & Nutrition Wellness Center to arrange for additional support. Iunderstandthatfailuretocompletethisapplicationfullyandreviewtheenclosedmaterialmaymean thedoctor willnotbeabletoconducttheconsultationandevaluation. I will also bring any labs, images or reports which have been requested in this application. I give this office permission to communicate with me via mail, telephone and email.

Signature: ____________________________________ Date: ______________________