

Confidential Medical History/ Evaluation

Name: _____ Date of Birth: ___/___/___ Referring MD: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:(Home) _____ (Cell/Work) _____ SSN: _____ Sex: _____

Primary Insurance: _____ Subscriber ID: _____ Group#: _____

Secondary Insurance: _____ Subscriber ID: _____ Group#: _____

Occupation: _____ Is this injury? Work Related Auto Accident

Chief Complaint: _____ Date of Injury: _____

Current Symptoms: Pain Numbness Stiffness Weakness Condition: New Chronic

List any/ all medications you are currently taking: _____

Are you allergic to any medications? _____

List any allergies: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI Xrays Other: _____

Do you have any of the following?			Pain when performing the following activities?			
	YES	NO	Mild	Moderate	Severe	Unable
Asthma, Bronchitis or Emphysema	_____	_____	_____	_____	_____	_____
Shortness of Breath/ Chest Pain	_____	_____	_____	_____	_____	_____
Coronary Heart Disease	_____	_____	_____	_____	_____	_____
Do you have a Pacemaker	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Heart Attack/ Surgery	_____	_____	_____	_____	_____	_____
Stroke/ TIA	_____	_____	_____	_____	_____	_____
Blood Clot/ Emboli	_____	_____	_____	_____	_____	_____
Epilepsy/ Seizures	_____	_____	_____	_____	_____	_____
Thyroid Trouble/ Goiter	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Infectious Disease	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Cancer or Chemo/ Radiation	_____	_____	_____	_____	_____	_____
Arthritis/ Swollen Joints	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Varicose Veins	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____
Sleeping Difficulties	_____	_____	_____	_____	_____	_____
Bowel or Bladder Changes	_____	_____	_____	_____	_____	_____
Severe/ Frequent Headaches	_____	_____	_____	_____	_____	_____
Vision/ Hearing Difficulties	_____	_____	_____	_____	_____	_____
Dizziness or Faintness	_____	_____	_____	_____	_____	_____
Are you pregnant ?	_____	_____	_____	_____	_____	_____

Other Medical Conditions _____

Are you aware of your Diagnosis? YES _____ NO _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier.

Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to The Smith Clinic regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/ Parent/Guardian Signature: _____ Date: _____

I acknowledge I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

EMERGENCY CONTACT

Please provide the name of a friend or relative that we may contact in the event of an emergency.

Name: _____ Relation: _____ Phone: (____) _____

I understand that The Smith Clinic will charge a \$20 fee for appointments missed without prior notification. Fee will be applied if twenty-four hour notification is not given.

Signature

Date

Please let us know who we can thank for sending you to our clinic:

Name: _____

Please answer the following questions regarding your therapy.

1. Have you attended physical therapy, occupational therapy, or been seen by a chiropractor this year?
Yes ___ No ___

Were your treatments related to the same injury you are being treated for at The Smith Clinic?
Yes ___ No ___

How many treatments have you had? _____

We occasionally send out information to our patients through email. Please provide us your email address so we can keep you informed. Thank you.

_____ @ _____