ADVANCED WELLNESS & SPORTS REHAB

We're Here for You Every Step of the Way

Dr. Diane K. Smith, DC, CCSP
Certified Chiropractic Sports Physician
Chiropractic Acupuncturist

PATIENT INFORMATION Date _____/_____/_____

Name: _____ _____ Name you'd prefer to be called: _____
LAST FIRST MI

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

Home Phone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Email: _____

You are opted in to our **text reminders** unless you specifically would like to opt out. ☐ Opt out

Date of Birth: ____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female ☐ _____

Occupation: _____ Employer: _____

Work Status: ☐ Full-Time ☐ Part-Time ☐ Not Working ☐ Retired ☐ Student ☐ Disability ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐ Other

Children: ☐ Yes ☐ No Age(s) _____

Name of Spouse/Significant Other: _____

Emergency Contact Name: _____ Phone (____) _____

How did you hear about us/whom may we thank for referring you? _____

INSURANCE / PAYMENT INFORMATION

Would you like to use your health insurance? ☐ Yes ☐ No Do you have Medicare or Medicaid? ☐ Yes ☐ No

Is your injury / illness work related? ☐ Yes ☐ No Date of Injury: ____/_____/_____

If yes, have you reported the injury to your employer? ☐ Yes ☐ No

Is your injury / illness related to an auto accident? ☐ Yes ☐ No Date of Accident: ____/_____/_____

If yes, please provide the following:

Auto insurance company name and address: _____

_____

Policy #: _____ Claim #: _____

OFFICE ONLY:

Primary insurance company name: _____

Insurance company address: _____

Phone #: _____ ID #: _____ Group #: _____

Primary policyholder's name: _____ Date of Birth: ____/_____/_____

☐ Additional information on back

ADVANCED WELLNESS & SPORTS REHAB, PA

PATIENT CONDITION

Patient Name: _____ Date: _____

Primary Complaint(s): _____

_____

Date you first noticed symptoms: _____ Describe how symptoms began: _____

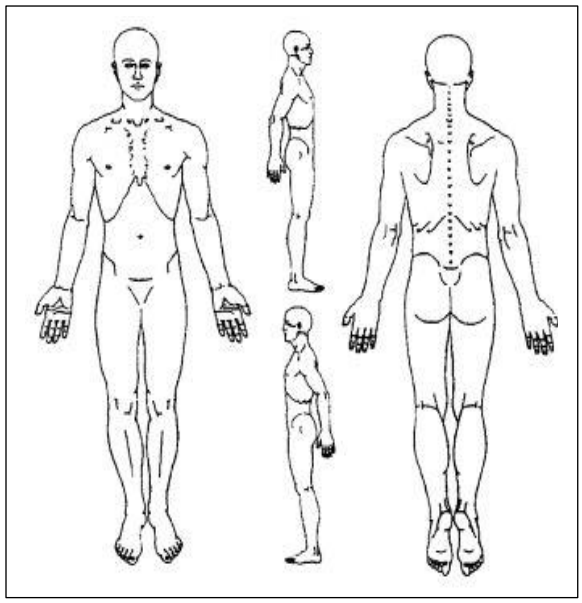
_____

Have you experienced this before? ☐ Yes ☐ No If yes, when? _____

How often do you have these symptoms?

- ☐ Constantly (76%-100% of the day)
- ☐ Frequently (51%-75% of the day)
- ☐ Occasionally (26%-50% of the day)
- ☐ Intermittently (0%-25% of the day)

PLEASE INDICATE AREA(S) OF COMPLAINT



How would you describe the quality of symptoms?

- ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Weakness
- ☐ Dull ☐ Burning ☐ Stiffness ☐ Throbbing
- ☐ Numb ☐ Tingling ☐ Cramps ☐ Achy

How have you symptoms changed since onset?

- ☐ Getting Better ☐ Getting Worse ☐ No Change

How would you rate your symptoms at best/worst:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Significant, preoccupied with seeking relief		Severe, activity is impossible

What worsens symptoms? _____

What improves symptoms? _____

Have you seen any other healthcare professional for this condition? ☐ Yes ☐ No If yes, please provide:

Provider Name: Address: Date:

_____

Did you have any imaging (x-ray,CT, MRI) or lab testing? ☐ Yes ☐ No Describe: _____

_____

Have you received chiropractic care in the past? ☐ Yes ☐ No Please list:

Provider Name: Address: Date:

_____

☐ Additional information on back

ADVANCED WELLNESS & SPORTS REHAB, PA

HEALTH HISTORY

Patient Name: _____

Past	Current		Past	Current		Past	Current	
☐	☐	Headache	☐	☐	Chemical Dependency	☐		Miscarriage
☐	☐	Neck Pain				☐	☐	Multiple Sclerosis
☐	☐	Upper/Mid Back Pain	☐	☐	Chest Pain	☐	☐	Nausea
☐	☐	Low Back Pain	☐	☐	Chronic Cough	☐	☐	Night Sweats
			☐	☐	Constipation	☐	☐	Pacemaker
☐	☐	Shoulder Pain	☐	☐	Depression	☐	☐	"Pinched" Nerve
☐	☐	ArmPain - Numbness	☐	☐	Diabetes	☐	☐	Pins/Needles Feeling in Limbs
☐	☐	Wrist Pain - Numbness	☐	☐	Digestive Issues			
☐	☐	Hand Pain – Numbness	☐	☐	Dizziness	☐	☐	Prostrate Problems
			☐	☐	Eating Disorder	☐		Stroke
☐	☐	Hip/Thigh Pain - Numbness	☐	☐	Excessive Thirst	☐	☐	Unexpected Recent Weight Gain/Loss
			☐	☐	Fatigue			
☐	☐	Knee/Lower Leg Pain - Numbness	☐	☐	Fever			
			☐	☐	Fracture(s)	☐	☐	Pain Sitting
			☐	☐	General Stiffness	☐	☐	Pain Walking
☐	☐	Facial Pain - Numbness	☐	☐	Glaucoma	☐	☐	Pain Running
☐	☐	Jaw Pain	☐	☐	Gout	☐	☐	Pain First-Thing in the Morning
			☐		Heart Attack			
	☐	AIDS/HIV	☐	☐	Heartburn			
☐	☐	Alcoholism	☐	☐	Hepatitis	FEMALES:		
☐	☐	Allergies	☐	☐	Herniated Disc	☐	☐	Contraceptive Use
☐	☐	Anemia	☐	☐	High Blood Pressure	☐	☐	Hormone Therapy
☐	☐	Arthritis	☐	☐	High Cholesterol	☐	☐	Painful Menstruation
☐	☐	Asthma	☐	☐	Kidney Disease			
☐	☐	Bowel/Bladder Changes	☐	☐	Liver Disease		☐	Currently Pregnant
☐	☐	Cancer – Location/Type:	☐	☐	Loss of Balance	Due Date: _____		
			☐	☐	Memory Problems			

_____

Additional Information/Other Conditions: _____

Family History (Arthritis, Cancer, Diabetes, Heart Disease, other): _____

Medications and Supplements: _____

EXERCISE

- ☐ None
- ☐ Light
- ☐ Moderate
- ☐ Heavy

HABITS

- ☐ Smoking Packs/Day: _____
- ☐ Alcohol Drinks/Week: ___
- ☐ Caffeine Cups/Day: _____

Previous Major Injuries: _____

_____

Previous Surgeries: _____

_____

Previous Accidents (Auto/Other): _____

_____

Goals from this treatment: _____

Signature: _____ Date: _____

☐ Additional information on back