WELCOME

ROCK COUNTY CHIROPRACTIC

Dr. Michael P. Smith, DC
103 E Main, Luverne, MN 56156
(507) 283-2561 PH (507) 283-1831 FAX

PATIENT INFORMATION

Date_____

Name_____

Address_____

_____

City State Zip

Email Address_____

Sex: □M □F Age____ Birth date_____

□ Single □ Married □ Widowed □ Separated □ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birth date_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

PHONE NUMBERS

Home_____Work_____Ext____

Cell_____ Best Time to Call_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____

Work Phone_____Ext_____

ACCIDENT INFORMATION

Is condition due to an accident? □ Yes □ No Date_____

Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Worker Comp. □ Other

Attorney Name (if applicable)_____

ADDITIONAL PATIENT INFORMATION

Race: (Please Check One)

____American Indian
____Asian
____Black or African American
____Decline to State
____Hispanic or Latino
____Native Hawaiian
____Other Pacific Islander
____White

Smoking Status: (Please Check One)

____Never Smoked
____Former Smoker
____Occasional Smoker
____Daily Smoker
____Decline to State

Medication Allergies:

____Yes
____No
If Yes, to what: _____

Preferred Language:

____English
____Other: _____

Height: _____

Weight: _____

PATIENT CONDITION

In your own words, where is the problem?_____

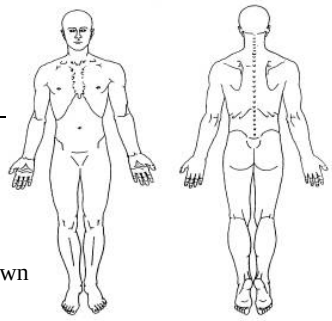
When did your symptoms appear?_____

Is this condition getting: □ Better □ Worse □ Stays the same □ Unknown

Mark an **X** on the picture where you have pain, numbness, or tingling

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: □ Sharp □ Dull □ Tingling □ Numbness □ Weakness □ Aching □ Shooting
□ Burning □ Throbbing □ Cramping □ Stiffness □Swelling □ Other_____



How often do you have pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Getting comfortable at night □ Recreation

Activities or movements that are difficult to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down
□ Coughing □ Sneezing □ Bowel movements

What makes your pain feel better? □ Ice □ Heat □ Medication □ Stretches □ Other_____

PATIENT SYMPTOMS

Please mark if you are experiencing any of the following symptoms:

☐ Back pain	☐ Back stiffness	☐ Chest pressure	☐ Dizziness	☐ Neck pain	☐ Neck stiffness	☐ Nausea	☐ Headaches
☐ Fatigue	☐ Irritability	☐ Tension	☐ Blurry vision	☐ Double vision	☐ Jaw problems	☐ Leg pain	☐ Memory loss
☐ Stomach upset	☐ Weight gain	☐ Night sweats	☐ Sleep difficulty	☐ Numb feet/toes	☐ Change in smell	☐ Numb hand/fingers	
☐ Ear buzzing/ringing		☐ Shortness of breath		☐ Arm/shoulder pain		☐ Abnormal bruising	
☐ Abnormal weight loss		☐ Change in taste/vision/hearing		☐ Abnormal heart rate/rhythm		☐ Blood in stool/urine/sputum	

PAST HEALTH HISTORY

What treatment(s) have you received for this condition? ☐ Medical/Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ None

☐ Other_____

Name of the provider who gave previous services?_____

Date of last: Physical Exam_____ Spinal Exam_____ Blood Test_____

Spinal X-ray_____ Chest X-ray_____ Urine Test_____

Dental X-ray_____ MRI/CT Scan_____ Bone Scan_____

Please mark on "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV ☐ Yes ☐ No	Drug Abuse ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Try ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Parkinson's ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pinched nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Other_____
Chicken Pox ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	
Diabetes ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	_____

Please list any of the following you have had:

Falls_____ Date_____

Head Injuries_____ Date_____

Broken Bones_____ Date_____

Dislocations_____ Date_____

Surgeries_____ Date_____

FAMILY HISTORY

Please list any member of your family (parents, grandparents, brothers or sisters) who have had the following:

Cancer_____ Lupus_____ Stroke_____

Rheumatoid Arthritis_____ Diabetes_____ Heart Disease_____

High Blood Pressure_____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy
- ☐ Cardiovascular
- ☐ Physical work

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

☐ Smoking Packs/Day_____

☐ Alcohol Drinks/Week_____

☐ Coffee/Caffeine Drinks Cups/Day_____

Stress Level: ☐ Low ☐ Moderate ☐ High

Why?_____

VITAMINS/MINERALS

_____

_____

_____

ALLERGIES

_____

_____

_____

MEDICATIONS

_____

_____

_____