Your History- Intake Form

Patient Information Date: / /

Patient Legal Name:			Nickname:
Address:			
City:		State:	Zip Code:
Home#:		Work#:	Cell#:
Email Address:			
Sex: M F	Occupation:	Marital Status: S / M / D / W	Birth Date: / /
Employer Name / Address:			
Emergency Contact:		Phone #:	Relationship to Patient:
Referred to HealthSmart by: Name:		Family Friend Close to home/work Internet Other	
We like to acknowledge our patients for referring others. If you prefer not to have your name mentioned please circle: No			
Appointment Reminders: Would you like to receive automated reminder calls for all future appointments? Yes No			
If yes, would you prefer an email, text or phone reminder? Email Text Phone			

What's your Wellness Quotient?				
Place an **X** that denotes where you believe is your current level of wellness.				
Place an **O** indicating where you would like your welness to be.				
Very Challenged 0-59	Challenged 60-69	Transition 70-79	Good 80-89	Excellent 90-100

Your Health Profile

What concerns bring you into our office? Please briefly describe the impact it has had on your life.
Rate Severity (Scale 1-10) 1 being Mild. When and how did this start? Are the symptoms Constant or Intermittant?
Since the problem started it is: (circle one) the same getting better getting worse

Care for the Whole Body *Welcome to the HealthSmart Experience!*

What makes the problem worse?

What, if anything, makes the problem feel better?

Does this interfere with your: (circle one) Liesure Work Sleep Sports Other

Describe:

Have you seen other doctors for this condition? Chiropractor MD Other

Name / Address

Date / / Diagnosis:

General History

Please list all medications you are taking and why: (Prescription and non Prescription)

Have you had any surgeries and/or hospitalizations? Yes No If yes, briefly explain:

Have you ever had any work related injuries? Yes No If yes, briefly explain:

Have you ever had any slips, falls, or auto accidents? Yes No If yes, briefly explain:

On a scale of 1 to 10 **(1=none, 10=extreme)**, describe your emotions/psychological/lifestyle stress levels:

Scale = Occupational stress:

Scale = Personal stress:

On a scale of 1 to 10 **(1=poor, 10=excellent)**, describe your habits and condition as it relates to:

Eating Exercise Sleep General Health Wellness Lifestyle

Please circle all symptoms you have ever had, even if they do not seem related to your current problem.

Headaches	Stomach upset	Eyes bothered by light
Migraines	Constipation	Irritability
Pins & needles in arms	Diarrhea	Mood swings
Pins & needles in legs	Menstrual pain	Loss of smell
Dizziness	Menstrual irregularity	Loss ot taste
Numbness in fingers	Hot flashes	Back pain
Fatigue	Cold sweats	Neck pain
Sleeping problems	Cold hands	Stiff neck
Tension	Cold feet	Numbness in toes
Ulcers	Fever	Fainting
Buzzing in ears	Urinary problems	Depression
Ringing in ears	Bedwetting	Concussion
High Blood Pressure		

Your Goals

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals.

Wellness Goals

Physical (Be Fit):

Nutrition (Eat Right):

Lifestyle (Think Well):

Are you on Medicare Part B? Yes No (If yes, please present your cards to the front desk.)

The above information is true to the best of my knowledge. I understand that I am financially responsible to pay for all services at the time of service as they are rendered and cannot be deferred to a later date.

Patient/Guardian signature Date

Photography and video recording is not permitted without permission and consent of the doctor.