Smart Pain Solutions LLC

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Patient Intake

Date: ____________ E-mail: ______________________________ Referred By: ____________________________________

Name: ____ Birthdate: ______________________ Age: ____________

Home Phone: _______________________ Work Phone: ________________________ Cell Phone: ______________________

Address: ____ City: __________________ State: ______ Zip: ______________

SS #____ Sex: □Male □Female

Occupation: ___________________________________ Employer/School: ____

□ Married □ Widowed □ Single □ Divorced □ Minor

Insurance Company Name: _____________________________________ Health Savings Account: □ Yes □ No

Secondary Insurance Company Name: ____

Spouse's Name: ________________________________ Spouse's Employer: ____

Have you ever received Chiropractic care? □Yes □No If so, When & Where? __________________________________

In Case of Emergency Contact:

Name: ____

Relationship: ____

Home phone: (_____) ______________________________

Work phone: (_____) ______________________________

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_______

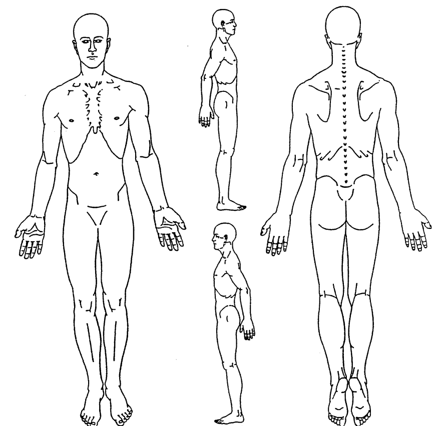
Attorney Name (if applicable): _____________________________

Attorney Phone Number: ___________________________________

Patient Complaints

Please List all of the complaints/problems you would like the doctor to look at today. Mark an X on the picture for each problem. Please prioritize them from most important to least important. You will be given complaint forms for each problem listed to more thoroughly describe each problem.

1. ____
2. ____
3. ____
4. ____
5. ____



Patient Name: **Date:**

Health History

To help us rule out any conditions which might be aggravated by massage, please fill in all the appropriate information.

Are you currently being treated for any medical condition? Medical, chiropractic, physical therapy or other treatment? □ No □ Yes

If yes, who is treating you, what is/are the condition(s), how long have you been treated and how are you being treated?

Physician	Condition	How Long	Type of Treatment

Do you have a primary care physician? □ No □ Yes Name: ______________________________ Date of Last: Physical Exam: ____________ Spinal Exam: ____________

Spinal X-ray: ____________ Chest X-ray: ____________ MRI, CT, Bone Scan: ____________

Blood Test: ____________ Urine Test: ____________

Are you Pregnant? □ No □ Yes Due Date: ______________

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

1. AIDS/HIV	□ Yes □ No	6. Epilepsy	□ Yes □ No	11. Migraines	□ Yes □ No	16. Prosthesis	□ Yes □ No
2. Arthritis	□ Yes □ No	7. Fractures	□ Yes □ No	12. MS	□ Yes □ No	17. Rheumatoid Arthritis	□ Yes □ No
3. Bleeding disorders	□ Yes □ No	8. Gout	□ Yes □ No	13. Osteoporosis	□ Yes □ No	18.Stroke	□ Yes □ No
4. Cancer	□ Yes □ No	9. Herniated Disk	□ Yes □ No	14. Pacemaker	□ Yes □ No	19. Tumors/Growths	□ Yes □ No
5. Diabetes	□ Yes □ No	10.Metal Implants	□ Yes □ No	15. Pinched Nerve	□ Yes □ No	20. Other____________	□ Yes □ No

If "Yes", please write the number of the condition and explain when it was diagnosed and how it was treated

#	*When you had it*	*How it was treated*	*Additional explanation*

Habits

Tobacco	□ Regularly	□ Rarely	□ Never	Explain________________
Alcohol	□ Regularly	□ Rarely	□ Never	Explain________________
Caffeine	□ Regularly	□ Rarely	□ Never	Explain________________
Exercise	□ Regularly	□ Rarely	□ Never	Explain________________
High Stress	□ Regularly	□ Rarely	□ Never	Explain________________

Would you be interested in additional information on any of the following?

□ Nutrition □ Exercise/Stretching □ Work Station □ Other ______________________

Injuries/Surgeries you have had	Description	Date
Falls		
Head injuries		
Broken Bones		
Dislocations		
Surgeries		
Car accidents		

Work Activity

What do you do for work: ______________________

□ Sitting □ Standing □ Computer □ Repetitious tasks

□ Lifting □ Weird postures □ Light labor □ Heavy labor

Is your desk set up ergonomically? □ No □ Yes

Do you take breaks? □ No □ Yes

Is your job stressful? □ No □ Yes Why?______________

Medications/Supplements

______________For:______________

______________For:______________

______________For:______________

______________For:______________

Allergies: ______________________