FOR DOCTOR USE ONLY:

What type of care would you desire so that we may assist you with your health care.

☐ **Relief Care** - Relief Care is care that is necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

☐ **Corrective Care -** Corrective care differs from relief care in that the goal is to get rid of the symptoms or pain while correcting the cause of the problem (fixing that leak). Corrective care varies in length of time for your treatment care and is more lasting.

Notes:_____

_____

_____

_____

_____

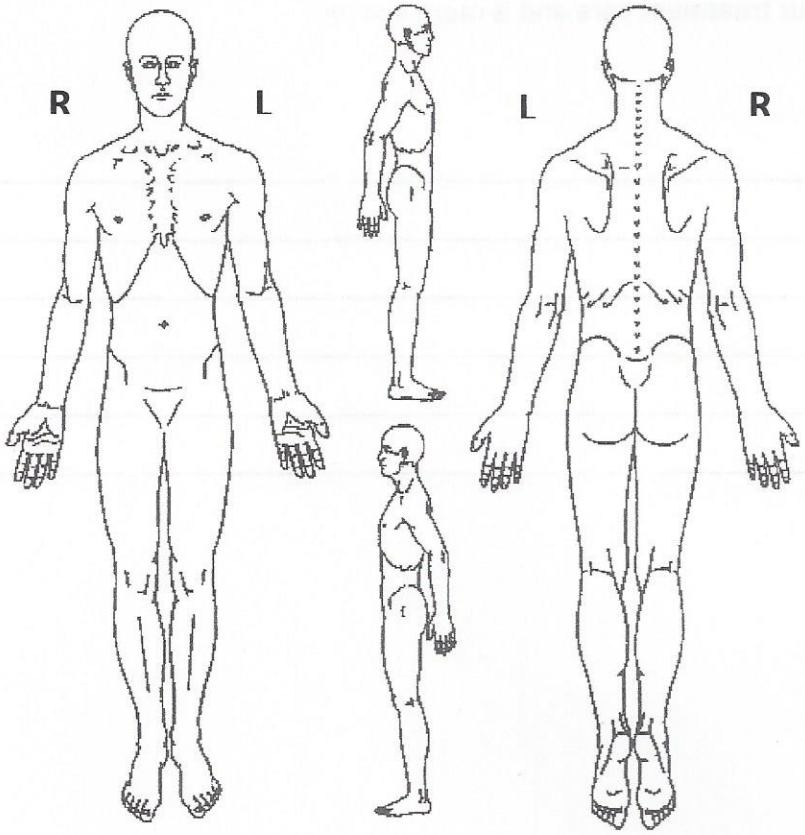
_____

PAIN DIAGRAM

PATIENT'S NAME_____ DATE_____

On the diagram below, please indicate where you are experiencing pain and other symptoms. Use the following to describe your symptoms:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing O = Other



Please rate your current level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Dr. Smith can treat his patients in two different ways. Please indicate your preference.

☐ **Proadjuster - using the latest technology to analyze and adjust your spine with no popping, twisting, or cracking** (there are little or no risks in using this kind of treatment).

☐ **Manual - traditional manipulation with popping, twisting, and cracking** (possible risks include broken bones, dislocations, sprains/strains, worsening/aggrativon of spinal conditions, increased symptoms and pain, vertebral artery dissection (stroke) when a patient receives a cervial adjustment).

☐ **Check here if you want the Doctor to select the type of adjustment for your condition.**

Insurance Assignment of Benefits and Release

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical thearpy and diagnostic x-rays, if needed. I hereby authorize Dr. Martin Smith to treat my condition as he deems appropriate and understand there are no guarantees in the results expected from the treatment.

I understand and agree that health and accident insurance policies are an arragement between the insurance carrier and myself. Smith Chiropractic, PC will prepare any necessary reports and forms to assist in billing the insurance company. I authorize any amount collected to be paid directly to Smith Chiropractic, PC and will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me which are not paid by my insurance will be charged directly to me and I am personally reponsible for payment. I authorize the use of this signature on all insurance submissions whether paper or electronic.

Print Name_____ **Date**_____

Signature_____

PRIVACY PRACTICE NOTICE &
PATIENT RIGHTS/RESPONSIBILITIES ACKNOWLEDGEMENT

This patient consent is for the use and disclosure of private health information for treatment, payment or healthcare operations.

I,_____, understand that as a part of my healthcare, Smith Chiropractic, P.C., orginates and maintains paper and/or electronic records describing my health history, symptoms, examinations, diagnosis and treatment plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis to my bill
- A means by which a third party payer can verify that services billed were provided

Should it become necessary to disclose my protected information to another health care provider or third party payer for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax.

I acknowledge that I have received a Privacy Practices Notice and Patient Rights/Responsibilites.

Print Name_____ **Date**_____

Signature_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including frequency and dosage if known. **If no current medications, check here:** ❑

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

List any known allergies you have had to any medications. **If no allergies are known, check here:** ❑

1) _____ 3) _____

2) _____ 4) _____

Briefly list your main health problems: _____

_____

Has any doctor diagnosed you with Hypertension (high blood pressure)? ❑ Yes ❑ No

Has any doctor diagnosed you with Diabetes? ❑ Yes ❑ No **If yes, what kind?** ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

In case of emergency please notify: _____ _____
Name *Phone*

Relationship: _____

To be performed by clinic staff:

Height: _____ **Weight:** _____ **BP:** _____ / _____ **Pulse:** _____

Smith Chiropractic, P.C.
1707 E. 20th St.
Farmington, NM 87402
(505) 327-5086

Patient Health History

Today's Date_____ **How did you hear about us?**_____

First Name_____ **MI**_____ **Last Name**_____

Preferred Name _____ **Patient Social Security #** _____

Mailing Address _____

City_____ **State**_____ **Zip Code**_____

Primary Phone_____ **Cell Phone**_____

Date of Birth_____ **Age** _____ **Gender** ❑ Male ❑ Female

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other_____

Employed by_____ **Work Phone**_____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Cell Phone ❑ Work Phone ❑ Home Email ❑ Work Email

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ African American ❑ Hispanic ❑ American Indian ❑ Asian ❑ Other

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ Other_____

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?

❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?

❑ What was the make of your first car? ❑ When is your anniversary?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.