Robert W. Smith, DC, DABCI
Diplomate America Board of Chiropractic Internists
4137 S. Sherwood Forest Blvd., Suite 110
Baton Rouge, Louisiana 70816
Telephone: 225-291-2626 Fax: 225-291-2628

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and provide effective use of your scheduled time.

Personal Information

Date_____ Nickname or preferred name _____

First, Middle, Last Name_____ Suffix: Jr. Sr. I II II_____

Address _____ City _____ State _____ Zip Code_____

Home Phone _____ Cell Phone _____

How did you hear about our office? ☐Friend ☐Dr._____ ☐Phonebook ☐Internet ☐ Location ☐ Other_____

Email address_____ Would you like our email newsletter? ☐Y ☐N

Age _____ Date of Birth ____/____/_____ Place of birth_____ SS#_____-_____-_____

Gender: ☐ Female ☐ Male Preferred Language: ☐English ☐Spanish ☐ French ☐Other_____

Genetic Background:

☐ African American ☐ Latino or Hispanic ☐Mediterranean ☐Asian ☐Alaska Native or American Indian
☐Caucasian ☐Northern European ☐ Native Hawaiian or Other Pacific Islander ☐Other _____

Advance Directives: ☐ Living Will ☐ Durable Power of Attorney ☐ Do not Resuscitate ☐ Other_____

Your Occupation _____ Hours per week _____ Retired _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse or Significant Other Name _____ Phone_____

Emergency Contact Name_____ Relationship_____ Phone_____

Address, City, St and Zip _____

PCP Name_____Address_____

Present Complaint

Is your visit today the result of ☐just pain, no trauma involved ☐work accident (current or previous employment)
☐automobile accident ☐accident, another type ☐other _____

Briefly describe symptoms_____

_____

_____

Other doctors seen for this condition_____ Treatment rendered_____

Are you taking any medication? ☐N ☐Y, What kind? _____

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Request for Records Release

Hospital or Facility Name_____

Physician Name _____

Street Address_____

City _____ State _____ ZIP Code _____

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name _____

Address _____

City _____ State _____ ZIP Code _____

Date of Birth _____ Social Security Number _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file.

Please release:

☐ Discharge Summary	☐ Laboratory	☐ X-ray Report(s)
☐ History and Physical	☐ Cardiology	☐ MRI Report(s)
☐ Consultation Reports	☐ Clinic Visit	☐ Record of Treatment
☐ Pathology Reports	☐ Entire Record	☐ Other_____

I _____hereby authorize _____ to release,
Full name of patient — Name of doctor, hospital or facility

specified information indicated by a check above, from my medical records covering dates of service _____ to _____to Robert W. Smith, DC, DABCI. Please send the records by fax to 225.291.2628 or mail to PO Box 40362, Baton Rouge, LA 70835. Thank you for expediting this request.

Patient's Signature: _____ Date: _____
(or parent if patient is a minor)

Signature of Authorized Representative_____ Relationship to Patient_____

Signature of Witness: _____

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Health Insurance Information

Name of person responsible for account_____ Method of payment_____

Relationship to insured: ☐ Self ☐Spouse ☐ Child ☐ Other

Patient status: ☐ full-time student ☐ part time-student ☐ Employed ☐ Retired ☐ Other_____

Is the condition we are treating related to current or previous employment? ☐ Yes ☐ No

Is the condition we are treating related to an auto accident? ☐ Yes, State_____ ☐ No

Is the condition we are treating related to another type of accident? ☐ Yes ☐ No

If insured is self, please complete this section below.

☐ *Health Insurance* ☐*Aetna* ☐*BCBS* ☐*Cigna* ☐*Coventry* ☐*Humana* ☐*UHC* ☐*Other*_____

Member/Subscriber ID #_____ Group_____

Employer of Subscriber_____Phone _____

Address, City, St and Zip _____

If insured is someone other than yourself, please complete appropriate section information below.

☐ *Health Insurance* ☐*Aetna* ☐*BCBS* ☐*Cigna* ☐*Coventry* ☐*Humana* ☐*UHC* ☐*Other*_____

Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other

Insured's Full Name_____ Insured's Date of Birth_____

Address_____City, St., Zip _____

Home Phone_____ Cell Phone _____ SS#_____-_____-_____

Employer of subscriber_____

Member/Subscriber ID #_____ Group_____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. I also request and authorize payment of benefits to the above listed physician or provider for service(s) rendered to me. I understand that any care not paid for by my existing insurance coverage will require payment in full at the time services are rendered or upon notice of insurance claim denial. This is to serve as a long-term authorization until revoked in writing.

Signed_____Date_____

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Medical History Form

Current Complaints:

When was the last time that you felt well? _____

Briefly describe your symptoms_____

_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

Are you taking any medication or nutritional supplements? ☐No ☐Yes, see attached sheet

How is your general health? ☐Excellent ☐Good ☐Fair ☐ Poor ☐Undetermined

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Life Style:

Yes	No	
☐	☐	Tobacco___ packs/day
☐	☐	Alcohol __drinks/day/week/month
☐	☐	Drug or Alcohol Dependence
☐	☐	Coffee/Tea/Caffeinated Soft drinks _____cups/cans per day
☐	☐	Exercise ☐daily ☐several times a week ☐ occasionally ☐ never

Past Medical History:

Have you had any past significant accidents or injuries? _____

Have you had any surgeries? If so, what surgeries? _____

Have you been hospitalized? If so, please describe the reasons?_____

Have you had any unusual diseases? _____

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Have you been treated for any significant health conditions by a physician in the last year? If so, please explain:

Have you or any relative received Chiropractic treatment previously? If so, please explain:

Have you been told you have any problems with any of these**? If so, please circle anything that applies to you:**

Nervous System (nerves) : Any changes in sight, smell, hearing, taste, seizures, faints, fits, headache, pins and needles, numbness, limb weakness, poor balance, speech problems, sphincter disturbances, higher mental function, psychiatric symptoms, other _____

Eyes, Ears, Nose, Throat: Visual Changes, headache, eye pain, double vision, scotomas, floaters, feeling like a curtain got pulled down, other _____

Cardiovascular System or Heart: Chest pain, shortness of breath, exercise intolerance, difficulty breathing at night, can breathe comfortably only when standing or sitting, Edema (swelling), palpitations (abnormal heartbeat), faintness, loss of consciousness, claudication (cramping or lack of blood flow in arms and/or legs), other _____

Histology or Lymph System: Anemia, Purpura (purple spots on skin), other _____

Respiratory System (lungs or breathing): Cough, Sputum (coughed up mucus), wheezing (continuous sound with breathing), Hemoptysis (coughing up of blood or bloody sputum), other _____

Gastrointestinal System (stomach and digestion): Abdominal pain (stomach pain), Unintentional weight loss, difficulty swallowing solids vs. liquids, indigestion (stomach troubles), bloating (abnormal swelling/tightness of stomach, cramping (pain and tightness in stomach), Nausea (sensation of unease and discomfort in upper stomach), vomiting (throwing up), Diarrhea (loose stool), constipation (hard to pass bowel movements), inability to pass gas, vomiting blood (throwing up blood), bright red blood in stool, foul smelling black tarry stools, dry heaving, other _____

Genitourinary System (elimination system): Discharge, pain, difficulty urinating, incontinence (not able to control urination), dysuria (painful urination) hematuria (blood in urine), polyuria (production of a large amount of urine), hesitancy (difficulty starting urine flow), terminal dribbling (continuing to leak urine after urination), decreased force of stream (decreased or intermittent urine flow), other_____

Organs/Skin: Thyroid symptoms, hyperthyroid (too much thyroid production), hypothyroid (too little thyroid production), prefer hot weather, prefer cold weather, mood swings, sweaty, diarrhea (loose stools), oligomenorrhea (infrequent or light periods), Weight loss despite increased appetite, tremor (shaking), palpitations (abnormal heart beats), visual disturbances, slow, tired, depressed, thin hair, croaky voice, heavy periods, constipation, dry skin, diabetes (polydipsia), puritis (itching), rashes, other_____

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Allergies or your Immune System: Known Allergies, Seasonal allergies, Other_____

Muscles or bones: Pain, stiffness, joint swelling, joint swelling morning, joint swelling entire day, functional deficit (loss of use of muscle or joint), joint swelling improves with activity, joint swelling worsens with activity, arthritis, other_____

Loss of weight, fever or loss of energy: Unexplained weight loss, night sweats, fatigue (lack of energy and motivation), malaise (general discomfort/uneasiness/out of sorts), Lethargy (feeling lazy, sluggish or indifferent), sleeping pattern disturbance, appetite changes, fever, itch, rash, lump, bumps, masses, unexplained falls, other_____

Hospitalizations/Surgical Procedures (List if not described elsewhere)_____
_____

Medication (list if not listed elsewhere)_____

Present *Weight* _____ Pounds *Height* _____Feet _____Inches

Female History: Women only - Please check any and all that apply to you.

Are you pregnant ☐Yes ☐No, date of last menstrual period?_____ Pregnancy, # births_____

Possible Pregnancy? ☐Yes ☐No ☐Less than 3 months ☐more than three months ☐other_____

Birth Control? ☐Yes ☐No ☐IUD ☐Birth Control Pill ☐Other_____

Do you experience cramping? ☐Yes ☐No ☐Mild ☐Moderate ☐Severe ☐1 day ☐2 days ☐3 days, ☐more than three days, other_____

Menstrual Flow: ☐Less than 3 days ☐Less than 4 days ☐Less than 5 days ☐More than 5 days ☐other

Date of last period: ☐Less than 1 week ☐less than 2 weeks ☐less than 3 weeks ☐less than 4 weeks ☐less than 5 weeks ☐other_____

Have you ever had a bone density scan? ☐Yes ☐No ☐Positive for Osteoporosis ☐Negative for Osteoporosis ☐other

Intermenstrual Discharge: ☐Yes ☐No ☐White or clear ☐non-offensive odor ☐offensive odor ☐pus like ☐white and clumpy ☐Grayish ☐Greenish ☐Yellowish ☐Blood Tinged ☐Accompanied by burning ☐accompanied by rash ☐accompanied by soreness ☐other_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

_____ _____
Signature **Date**

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Name_____ Date _____

Patient Health Questionnaire

1) If you have any listed symptom below please check the **present**, 2) please check that symptom in the Past Column, for **Past symptoms** and 3) **Family** for family history

Present	Past	Family	Condition	Present	Past	Family	Condition
☐	☐	☐	Abdominal Pain	☐	☐	☐	Abnormal Weight Gain/ Loss
☐	☐	☐	Angina	☐	☐	☐	Anorexia
☐	☐	☐	Aortic Aneurysm	☐	☐	☐	Arthritis
☐	☐	☐	Asthma	☐	☐	☐	Birth Control Pills
☐	☐	☐	Bladder Infection	☐	☐	☐	Blood Disorder
☐	☐	☐	Breast Lumps	☐	☐	☐	Breast Soreness
☐	☐	☐	Cancer, Explain_____	☐	☐	☐	Chest Pains
☐	☐	☐	Chronic Cough	☐	☐	☐	Chronic Sinusitis
☐	☐	☐	Colitis	☐	☐	☐	Constipation/irregular bowel habits
☐	☐	☐	Convulsions	☐	☐	☐	Diabetes
☐	☐	☐	Depression	☐	☐	☐	Dermatitis/Eczema/Rash
☐	☐	☐	Difficulty in Swallowing	☐	☐	☐	Dizziness
☐	☐	☐	Drug Dependences	☐	☐	☐	Emphysema (chronic lung disorders)
☐	☐	☐	Endometriosis	☐	☐	☐	Epilepsy
☐	☐	☐	Excessive Thirst	☐	☐	☐	Fainting
☐	☐	☐	Frequent Urination	☐	☐	☐	General Fatigue
☐	☐	☐	Hand Pain (L_____)	☐	☐	☐	Hand Pain (R_____)
☐	☐	☐	Headache _____	☐	☐	☐	Heart Attack (date)_____
☐	☐	☐	Heartburn/Indigestion	☐	☐	☐	Hemorrhoids
☐	☐	☐	Hepatitis Type _____	☐	☐	☐	High Blood Pressure
☐	☐	☐	Irregular Menstrual Flow	☐	☐	☐	Irritable Colon
☐	☐	☐	Jaw Pain	☐	☐	☐	Kidney Disorders (by condition)
☐	☐	☐	Kidney Stones	☐	☐	☐	Liver/Gallbladder problems
☐	☐	☐	Loss of Appetite	☐	☐	☐	Loss of Bladder Control
☐	☐	☐	Low Back Pain	☐	☐	☐	Mid Back Pain
☐	☐	☐	Muscular In-coordination	☐	☐	☐	Neck Pain
☐	☐	☐	Pain in Upper Arm or Elbow	☐	☐	☐	Pain in Upper Leg or Hip
☐	☐	☐	Pain in Lower Leg or Knee	☐	☐	☐	Pain in Ankle or Foot
☐	☐	☐	Painful Urination	☐	☐	☐	PMS
☐	☐	☐	Pregnancy	☐	☐	☐	Profuse Menstrual Flow
☐	☐	☐	Prostate Problems	☐	☐	☐	Rapid Heart Beat
☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐	Scoliosis
☐	☐	☐	Shoulder Pain	☐	☐	☐	Stroke (Date)_____
☐	☐	☐	Swelling, Stiffness of Joint(s)	☐	☐	☐	Tinnitus (Ear Noises)
☐	☐	☐	Tumor, Explain_____	☐	☐	☐	Ulcer
☐	☐	☐	Visual Disturbances	☐	☐	☐	Other_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition.

_____ _____

Signature **Date**