Dr. Diane K. Smith, DC, CCSP
Certified Chiropractic Sports Physician
Chiropractic Acupuncturist

PATIENT INFORMATION   Date _____/_____/________

Name: ___________________________ ______________________ Name you'd prefer to be called: _____________
LAST   FIRST   MI

Address: _____________________________ City: ____________________ State: ______ Zip: _________

Primary Phone: (_____) ________________ Email: ____

You are opted in to our **text reminders** unless you specifically would like to opt out. ☐ Opt out

Date of Birth: ____/_____/_______ Age: ______ Gender: ☐ Male ☐ Female ☐ _______

Occupation: _________________________ Employer: _________________________

Work Status: ☐ Full-Time ☐ Part-Time ☐ Not Working ☐ Retired ☐ Student ☐ Disability ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner ☐ Other

Name of Spouse/Significant Other: ________________________

Children: ☐ Yes ☐ No Age(s) _________________

Emergency Contact Name: _______________________ Phone (____) ______________

How did you hear about us/whom may we thank for referring you? __________________________________

INSURANCE / PAYMENT INFORMATION

Would you like to use your health insurance? ☐ Yes ☐ No Do you have Medicare or Medicaid? ☐ Yes ☐ No

Is your injury / illness work related? ☐ Yes ☐ No Date of Injury: ____/_____/______

If yes, have you reported the injury to your employer? ☐ Yes ☐ No

Is your injury / illness related to an auto accident? ☐ Yes ☐ No Date of Accident: ____/_____/______

If yes, have you filed with your auto insurance yet? ☐ Yes ☐ No

BY INITIALING BELOW, YOU ARE STATING THAT YOU HAVE REVIEWED EACH DOCUMENT AND HAVE BEEN OFFERED A COPY OF EACH:

_______ (initials) - Authorization to Release Health Information and Privacy Notice
_______ (initials) - Informed Consent About Risks of Chiropractic
_______ (initials) - Assignment of Benefits – assigning payment to our office from a 3rd party
_______ (initials) - Guarantee of Payment – you are responsible for any charges incurred and not paid by a 3rd party
_______ (initials) - Cancellation Policy – A fee of $35 may be charged for no shows or late cancellations

Name of anybody else you'd like us to be able to discuss your information with: ________________________

Consent for treatment of a **minor** ☐ Yes ☐ No Parent/Guardian ______ (initials)

☐ Additional information on back

ADVANCED WELLNESS & SPORTS REHAB, PA

PATIENT CONDITION

Patient Name: ____________________ Date: __________

Primary Complaint(s): ____

____

Date you first noticed symptoms: ___________ Describe how symptoms began: ____________________

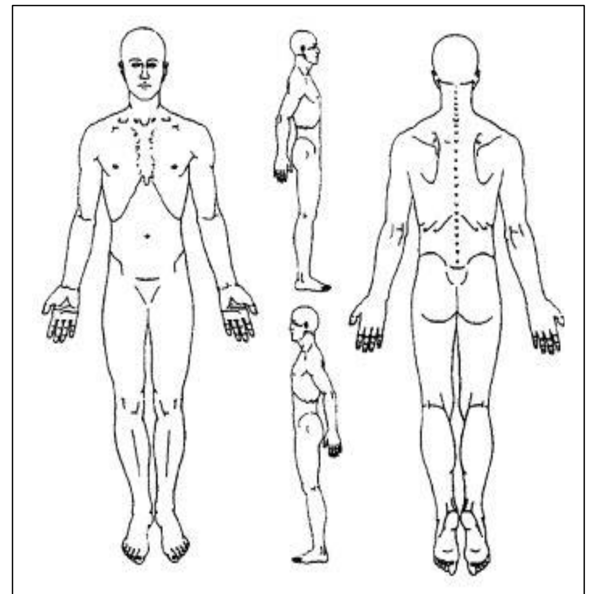
____

Have you experienced this before? ☐ Yes ☐ No If yes, when? ______________

How often do you have these symptoms?

☐ Constantly (76%-100% of the day)
☐ Frequently (51%-75% of the day)
☐ Occasionally (26%-50% of the day)
☐ Intermittently (0%-25% of the day)

PLEASE INDICATE AREA(S) OF COMPLAINT



How would you describe the quality of symptoms?

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Weakness
☐ Dull ☐ Burning ☐ Stiffness ☐ Throbbing
☐ Numb ☐ Tingling ☐ Cramps ☐ Achy

How have you symptoms changed since onset?

☐ Getting Better ☐ Getting Worse ☐ No Change

How would you rate your symptoms at best/worst:

	None										Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Significant, preoccupied with seeking relief		Severe, activity is impossible

What worsens symptoms? ____

What improves symptoms? ____

Have you seen any other healthcare professional for this condition? ☐ Yes ☐ No If yes, please provide:

Provider Name: Address: Date:

____

Did you have any imaging (x-ray,CT, MRI) or lab testing? ☐ Yes ☐ No Describe: _______________

____

Have you received chiropractic care in the past? ☐ Yes ☐ No Please list:

Provider Name: Address: Date:

____

☐ Additional information on back

ADVANCED WELLNESS & SPORTS REHAB, PA

HEALTH HISTORY

Patient Name: ________________________

Past	Current	
☐	☐	Headache
☐	☐	Neck Pain
☐	☐	Upper/Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	ArmPain - Numbness
☐	☐	Wrist Pain - Numbness
☐	☐	Hand Pain – Numbness
☐	☐	Hip/Thigh Pain - Numbness
☐	☐	Knee/Lower Leg Pain - Numbness
☐	☐	Facial Pain - Numbness
☐	☐	Jaw Pain
	☐	AIDS/HIV
☐	☐	Alcoholism
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bowel/Bladder Changes
☐	☐	Cancer – Location/Type: ______________________________

Past	Current	
☐	☐	Chemical Dependency
☐	☐	Chest Pain
☐	☐	Chronic Cough
☐	☐	Constipation
☐	☐	Depression
☐	☐	Diabetes
☐	☐	Digestive Issues
☐	☐	Dizziness
☐	☐	Eating Disorder
☐	☐	Excessive Thirst
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Fracture(s)
☐	☐	General Stiffness
☐	☐	Glaucoma
☐	☐	Gout
☐		Heart Attack
☐	☐	Heartburn
☐	☐	Hepatitis
☐	☐	Herniated Disc
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Loss of Balance
☐	☐	Memory Problems

Past	Current	
☐		Miscarriage
☐	☐	Multiple Sclerosis
☐	☐	Nausea
☐	☐	Night Sweats
☐	☐	Pacemaker
☐	☐	“Pinched” Nerve
☐	☐	Pins/Needles Feeling in Limbs
☐	☐	Prostrate Problems
☐		Stroke
☐	☐	Unexpected Recent Weight Gain/Loss
☐	☐	Pain Sitting
☐	☐	Pain Walking
☐	☐	Pain Running
☐	☐	Pain First-Thing in the Morning

FEMALES:

Past	Current	
☐	☐	Contraceptive Use
☐	☐	Hormone Therapy
☐	☐	Painful Menstruation
	☐	Currently Pregnant

Due Date: ____________

Additional Information/Other Conditions: ____

Family History (Arthritis, Cancer, Diabetes, Heart Disease, other): ________________________________

Medications and Supplements: ____

EXERCISE

- ☐ None
- ☐ Light
- ☐ Moderate
- ☐ Heavy

HABITS

- ☐ Smoking Packs/Day: ______
- ☐ Alcohol Drinks/Week: ___
- ☐ Caffeine Cups/Day: ______

Previous Major Injuries: ________________________

____

Previous Surgeries: __________________________

____

Previous Accidents (Auto/Other): ______________

____

Goals from this treatment: ____

Signature: ____ Date: ___________

☐ Additional information on back

Form 1-2015, 3-2020, 6-2022