CHIROSMART

405 N. Hershey Road, Suite 6
Bloomington, IL 61704
TELEPHONE: (309)808-3260

Check symptoms you are currently experiencing

☐ Headache	☐ Irritability	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of breath	☐ Buzzing in ears	☐ Hands cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Sleeping Problems	☐ Head seems too heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & needles in arms	☐ Lights bother eyes	☐ Loss of smell	☐ Cold sweats
☐ Nervousness	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Tension	☐ Numbness in fingers	☐ Ears ring	☐ Diarrhea	

List all symptoms other than above: _____

INJURIES? (Automobile Accidents, Slips and falls, etc.) and when: _____

_____

FAMILY HISTORY: (Please list any family illness, such as tuberculosis, diabetes, cancer or high blood pressure and which family member experienced them.)

_____

_____

TOTAL DISABILITY: From _____ To _____

PARTIAL DISABILITY: From _____ To _____

Total days of work missed: _____

FEMALE HISTORY:

Date of last menstrual cycle: _____ ☐ Regular ☐ Irregular | Birth control pills? ☐ Yes ☐ No

Are you pregnant at this time? ☐ Yes ☐ No ☐ Unsure

MISCELLANEOUS INFORMATION

How did you hear about us?

☐ Newspaper ☐ Billboard ☐ Radio
☐ TV ☐ Employer ☐ Bus Ad
☐ Digital Ad ☐ Word of mouth
☐ Friend or Relative If so, their name: _____

I understand and agree that the only insurance submitted is for a personal injury accident case. Personal injury accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chirosmart will prepare any necessary reports and forms to assist me in making collection from the personal injury insurance company and that amount authorized to be paid directly to Chirosmart will be credited to my account upon receipt. However, I clearly understand and agree that ANY services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that I am responsible for all costs of chiropractic treatment regardless of insurance coverage. I understand that I am responsible for court costs, attorney's fees and all costs of collection.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

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CONFIDENTIAL PATIENT INFORMATION

Date: _____ Drivers License #: _____

Name: _____

Cell Phone: _____ Email: _____ Home Phone: _____

Address: _____ City: _____ Zip Code: _____

Age: _____ DOB: _____ Marital Status: ☐M ☐S ☐W ☐D Number of Children: _____

Occupation: _____ Employer: _____ Office Phone: _____

Address: _____ City: _____ Zip Code: _____

Name of Spouse: _____

Occupation: _____ Cell Phone: _____

Nearest Relative: _____ Relationship to you: _____

Email: _____ Cell Phone: _____

MISCELLANEOUS INFORMATION

Date of last physical exam: _____ Operations? Dates: _____

Serious Illnesses? _____ When? _____

Have you been treated for any health condition by a physician in the past year? ☐ Yes ☐ No

If yes, please describe: _____

What medication, drugs or vitamins are you presently taking? _____

Have you ever received Chiropractic care before? ☐ Yes ☐ No

Please list below the five main complaints you have, in the order of most importance (worst pain first.)
Also, the length of time you have had this complaint and the doctors who have treated you.

List complaints with the most severe first.	When did symptoms first appear?	List other doctors seen for each condition.
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE