DR. JEDIDIAH T. SMITH

PATIENT INTAKE FORM

Upper Cervical Doctor of Chiropractic
1732 Palma Drive, Suite 104, Ventura, CA 93003
805.642.6565

First M Last

Address

Phone

City State Zip Code

Cell Phone

Email

Sex: M F

Marital: S M W D

Birthdate

Social Security (Medicare only)

Referred By

Occupation

Emergency Contact Phone

Medical Doctor Phone

Financial Responsibility:

Payment is due when services are rendered, unless prior written arrangement has been made.

Please speak with the Office Manager before seeing the Doctor if you have any questions or concerns.

Patient Signature Date

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_____

First M Last

Height _____ Weight _____ Blood Pressure _____

Reason(s) for seeking Chiropractic care: _____

Please describe HOW your problem started: _____

_____

Date your problem started: _____ Have you had this in the past? Y / N

Rate your pain if any (0=none / 10=unbearable): 0-1-2-3-4-5-6-7-8-9-10

Describe your pain if any (e.g. sharp, dull, burning): _____

Did it start: Suddenly / Gradually Is it: Constant / Intermittent

What activities make it better? _____

What activities make it worse? _____

How is this affecting your daily life and goals? _____

Have you received prior treatment for this condition and how effective was it? _____

_____

List any other symptoms that started about the same time (constipation, nausea, headaches, deafness)

_____

Please list ALL current medications and supplements: _____

_____

Do you smoke, drink alcohol, and/ or take recreational drugs: _____

List all broken bones/ surgeries/ serious accidents/ falls: _____

_____

Please list any additional information you would like the Doctor to know _____

_____

_____

_____

Patient Signature Date