Cynthia Smith Chiropractic & Acupuncture 949-565-5015

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F Marital status: S M D W

Phone No. _____ Cell / Home Email: _____

Address: St. _____Apt_____City_____State _____Zip_____

Emergency Contact (Name, Phone No & Relationship) _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to CSCA in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health (G=Good, P=Poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever/Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Other

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____
2. # of Days of Menses: _____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N

a. Explain: _____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

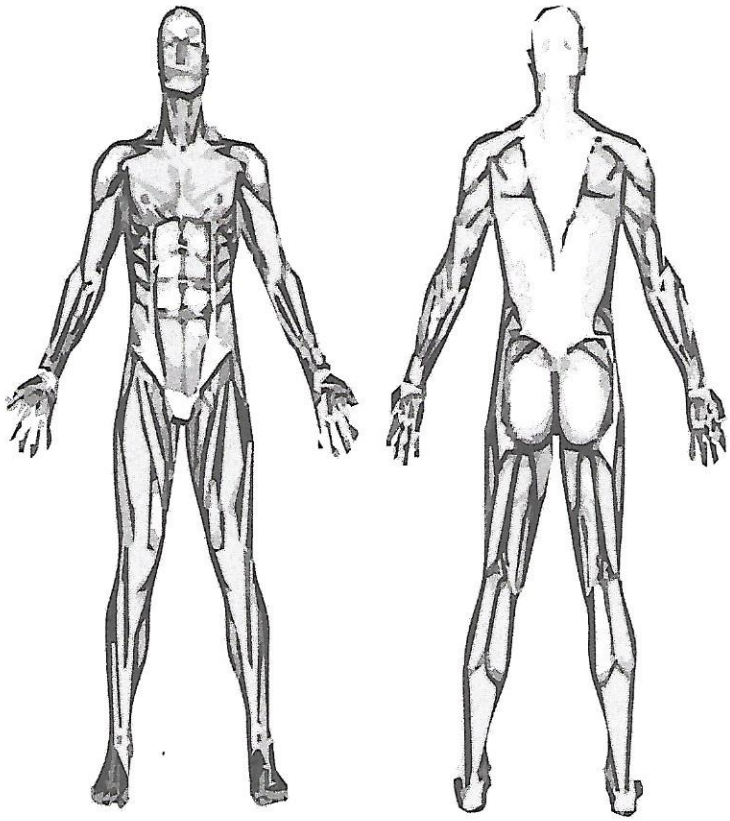
l. Anything else you'd like the doctor to know? _____

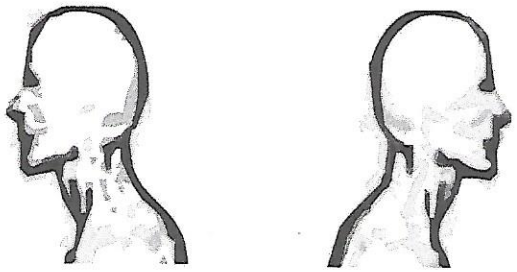
Have you ever suffered from:

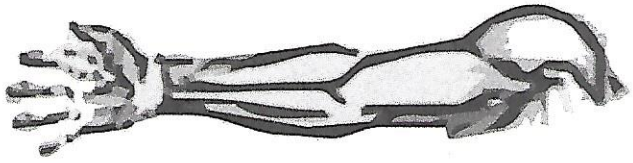
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

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







INFORMED CONSENT FOR CHIROPRACTIC AND/OR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic adjustments, acupuncture treatment or any other procedures performed on me (or on the patient named below for which I am legally responsible) which are recommended by Dr. Cynthia Smith. Procedure(s) consented to may include but are not limited to examinations, chiropractic adjustments, acupuncture, acupressure, myofascial release, therapeutic exercises, electrical stimulation, ultrasound, nutritional counseling, tui-na, gua-sha, infrared light, acupuncture electrical stimulation, cupping therapy, and herbal/nutritional counseling. During an acupuncture treatment Dr. Smith may insert sterile, single-use needles on various acupuncture points on your body.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment and/or acupuncture treatment. While rare those complications from a chiropractic adjustment include but are not limited to fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy or costovertebral strains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to stroke or other serious complications. Dr. Smith will carefully review your medical history and evaluate which treatment best fits your condition before application of any therapy. On rare occasions acupuncture may have side effects such as dizziness, fainting, bruising, numbness or tingling near the needling sites that may last a few days. Slight bruising is a possible side effect of acupuncture and cupping therapy. Mild burns and/or scarring are a possible risk of moxibustion or cupping. Highly unusual risks of acupuncture may include infections, spontaneous miscarriage, minor nerve damage, and organ puncture. We comply with strict protocols for needle usage and associated healing modalities. I understand while this document describes the possible risks of treatments, other side effects may occur.

Informed Consent for Herbal Medicine:

Eastern Medicine uses and recommends herbs and nutritional supplements from plant, animal, and mineral sources which are traditionally considered safe. Herbs come in either capsules or granule (tea) forms. Some may have an unpleasant smell or taste. So capsule form may be easier. Though rare, possible side effects from taking herbs or supplements include nausea, stomach ache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. Taking large doses may be toxic. Some herbs may be inappropriate during pregnancy. I will notify the doctor if I may be pregnant or suspect that I am pregnant before each treatment begins. I understand that the recommended herbs/supplements need to be consumed according to the doctor's instructions. I will immediately notify Dr. Smith of any unanticipated or unpleasant effects associated with the consumption of the herbal recommendations.

I do not expect the Dr. Smith to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the Doctor to exercise judgment in my best interest during the procedure(s), which the Doctor feels at the time based upon the facts then known.

By voluntarily signing below, I show that I have read, or have had read to me, the entire contents of this Informed Consent Form. I understand the risks and benefits of chiropractic and acupuncture associated procedures. I have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment with my chiropractor/acupuncturist at Cynthia Smith Chiropractic & Acupuncture.

_____
Signature of Patient or Personal Representative

_____
Signature of Provider

_____
Print name of Patient or Personal Representative

Cynthia Smith DC, LAc, CHt
Print name of Provider

_____
Date of Consent