LaCroix Health Center

37 Doctors Park Suite 5 Cape Girardeau, MO 63703 P: (573) 334-0778 F: (573) 334-0776
Dr. Scott B. Smith, DC

Patient Information*:* Date: _____

Patient Name: _____
Last First MI

Mailing Address _____
City State Zip

Sex: M F Birthdate_____/_____/_____ Age: _____ Social Security Number _____-_____-_____

Occupation _____Employer_____

Whom may we thank for referring you? _____

Insurance Information: *(Please provide us with a copy of your insurance cards for our records)*

Primary: _____ Secondary: _____

What services are you visiting our office for today or would you be interested in knowing more about?
(Check all that apply)

☐ Chiropractic ☐ Lipo Laser ☐ Medical Weight Loss

Heath History *(cont'd*

Have you recently suffered from a heart attack or stroke? ☐**Yes** ☐**No**
If yes, how long ago _____

Has a physician treated you for any other condition(s) in the past 12 months? ☐**Yes** ☐**No**
If yes, please explain _____
_____

Exercise

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Vigorous (>4x/wk, 30 min)

Activities: _____
_____

Work Activity

1. ☐ Sitting
2. ☐ Standing
3. ☐ Light Labor
4. ☐ Heavy Labor
5. ☐ Other_____
   _____
   _____

Habits

Smoking _____ Packs/day
Alcohol Use _____Drinks/week
Coffee/Caffeine Drinks _____ Cups/day
How many hours do you sleep a night? ____
Stress Level (Low) 1 2 3 4 5 6 7 8 9 10 (High)
Stress Management Techniques Used:
_____
_____

Please describe for us any hospitalizations, serious illnesses, falls, broken bones, or surgeries you have had:

Year	Reason	Hospital	Outcome

Please provide details of any known allergies (eg. Latex, foods, medications, etc.)

Allergen	Reaction

Patient Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I understand and agree to the ***LaCroix Health Center*** Privacy Practices which describes how my protected medical information may be used and disclosed, and may be given a copy to take if requested.

Signed: _____ Date: _____

I authorize ***LaCroix Health Center*** *(and its affiliates)* to discuss and/or release my medical information including labs and test results, diagnosis, and treatments discussed to the following persons:

Name_____ **Relationship**_____ **Phone:** _____
Name_____ **Relationship**_____ **Phone:** _____
Name_____ **Relationship**_____ **Phone:** _____

This information can be updated at any time and we will provide you with a new form to complete.
Please circle the answer that applies below along with the NECESSARY INFORMATION:

			Phone Number
May we contact you at home?	**Yes**	**No**	_____
May we leave **detailed** messages on your cell phone?	**Yes**	**No**	_____
May we leave **detailed** messages on your home phone?	**Yes**	**No**	_____

EMERGENCY CONTACT INFORMATION:
In case of an **EMERGENCY**, please contact the below listed person(s). You may discuss any of my medical information necessary for my medical treatment or well-being.

Name_____ **Relationship**_____ **Phone:** _____
Name_____ **Relationship**_____ **Phone:** _____

Printed Name: _____Patient Signature: _____
Parent Signature *(if under 18)*: _____ Date: _____