Dr. Scott B. Smith, DC
Ph. (573) 334-0778

LaCroix Health Center, LLC
37 Doctors Park Suite 5
Cape Girardeau, MO 63703

Patient Information*:*

Date: _____

Patient Name: _____/ _____/ _____ Marital Status: S M D
Last First MI

Address: _____ City: _____ State: _____ Zip: _____

Ph. _____ Birthdate_____/_____/_____ Age: _____ Sex: M F

Is this the result of an accident? **Y N**

Symptom Questionnaire:

What type of care are you looking for? ☐ Temporary Relief ☐ Maximum Recovery

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1._____ 3._____

2_____ 4._____

Check all of the following symptoms you have experienced in the last 6 months

Joint Pain:	**Joint Stiffness:**	**Decreased Motion:**	**Other:**
neck	neck	neck	Diabetes
back	back	back	Neuropathy
knee R L	knee R L	knee R L	pain on resting
shoulder R L	shoulder R L	shoulder R L	pain w/movement
hip R L	hip R L	hip R L	swelling
elbow R L	elbow R L	elbow R L	other_____
hand R L	hand R L	hand R L	
foot R L	foot R L	foot R L	
other_____	other_____	other_____	

Describe the way your pain feels: ***(Check all that apply)***

☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Burning ☐Tingling ☐ Aching ☐Numb
☐ Other _____

Symptoms developed from: ☐ Illness ☐ Unknown Cause ☐ Job related injury(DATE: ____/____/_____) ☐ Auto Accident (DATE: ____/____/_____) ☐ Other Accident _____ (DATE: ____/____/_____) ☐GRADUAL ONSET (DATE: ____/____/_____)
☐ Other _____

Symptoms have persisted for # _____HOUR(S) _____DAY(S)_____WEEK(S)_____MONTH(S)_____YEAR(S)

Symptoms/Complaints: ☐Come and Go ☐Constant **Have you ever had this before:** ☐NO ☐ YES *(WHEN?* _____*)*

Symptoms are worse in the: ☐ Morning ☐ Afternoon ☐ Evening

Is there any other health problem that concerns you besides your major complaint? _____
_____

What is your pain on a scale of 1- 10? 0 1 2 3 4 5 6 7 8 9 10

What percentage of time do you experience this pain?

☐Constant *(75-100%)* ☐ Frequent *(50-74%)* ☐ Off/On *(25-49%)* ☐ Occasional *(0-24%)*

Over

Symptom Questionnaire:

Does this cause you to suffer any of the following?*(Check all that apply)*

☐Moodiness ☐Irritability ☐ Restricted Activities ☐Reduced Daily Activities ☐ Depression
☐Decreased Productivity ☐Exhaustion at the End of the Day ☐ Being Unable to Work Long Hours
☐ Other _____

Does this affect your life in any of the following ways? *(Check all that apply)*

☐Lose patience with spouse/family ☐Restricted household duties ☐ Hinders ability to participate in sports
☐ Inhibits Ability to Participate in Hobbies or Other Desired Activities ☐ Reduced Decision Making
☐ Other _____

Does this affect your life in any of the following ways? *(Check all that apply)*

☐Lose patience with spouse/family ☐Restricted household duties ☐ Hinders ability to participate in sports
☐ Inhibits Ability to Participate in Hobbies or Other Desired Activities ☐ Reduced Decision Making
☐ Other _____

Because healing occurs when you are asleep, and sleep is essential to proper immune system function, do you suffer from any of the following problems with sleeping? *(Check all that apply)*

☐ Trouble Falling Asleep ☐ Trouble Staying Asleep/ Awakening in the Middle of the Night ☐ Not Enough Restful Sleep
☐ Waking Earlier than You Would Like ☐ Other: _____

What other treatments have you tried? *(Injections, physical therapy, etc.)*

1._____ 5._____
2_____ 6._____
3._____ 7._____
4._____ 8._____

What were the results of those treatments?

1._____ 5._____
2_____ 6._____
3._____ 7._____
4._____ 8._____

Office Policies and Consent:

By signing below, I hereby authorize, consent and request Dr. Smith, or any an attending physician, to administer such treatment as deemed advisable, including, but not limited to: chiropractic manipulations, physical therapy, physical examination, counseling, x-rays and neurological testing. I agree to hold him harmless from any claims, suits, damages or complications which may result from performing such.

I certify that all the information contained in this form is correct to the best of my knowledge. I will not hold the doctor or any members of the staff responsible for any errors or omissions that I may have made in completion of this form.

I agree to inform the doctor or staff if there are any changes to my medical history, current medications prior to any future treatments.

Printed Name: _____

Signature: _____ Date: _____/_____/_____