Advanced CHIROPRACTIC

Welcome

Patient Name: _____ What do you preferred to be called?: _____

Birthdate: ____/____/____ Age: ___ ❑Male ❑Female E-Mail Address: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone # _____

Preferred Language: _____ Social Security Number: _____

Referred Source: _____ Do you have children? ❑No ❑Yes How Many: _____

Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed Spouse's Name: _____

Account Information (Person ultimately responsible for account):

☐Same as above

Name: _____ Relation: _____ Work Phone: _____

Billing Address: _____ City, State, Zip: _____

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company if offered at this office.

Complaint #1:_____ Side: _____

What makes the above region feel worse?:_____ _____

What makes the above region feel relief?: _____

What time of day are your symptoms worst?: _____

What percentage of your day is this pain present: _____ Pain Intensity (0= no pain, 10= worst imaginable pain): _____

Which of the following describes the quality of your pain: ↓

☐Burning	☐ Stiff
☐ Sharp	☐ Tingling
☐ Shooting	☐ Throbbing
☐ Dull	☐ Swelling
☐ Achy	☐ Numb

How and when did this ailment begin?: _____

Comments: _____

Complaint #2:_____ Side: _____

What makes the above region feel worse?:_____ _____

What makes the above region feel relief?: _____

What time of day are your symptoms worst?: _____

What percentage of your day is this pain present: _____ Pain Intensity (0= no pain, 10= worst imaginable pain): _____

Which of the following describes the quality of your pain: ↓

☐Burning	☐ Stiff
☐ Sharp	☐ Tingling
☐ Shooting	☐ Throbbing
☐ Dull	☐ Swelling
☐ Achy	☐ Numb

How and when did this ailment begin?: _____

Comments: _____

Complaint #3:_____ Side: _____

What makes the above region feel worse?:_____ _____

What makes the above region feel relief?: _____

What time of day are your symptoms worst?: _____

What percentage of your day is this pain present: _____ Pain Intensity (0= no pain, 10= worst imaginable pain): _____

Which of the following describes the quality of your pain: ↓

☐Burning	☐ Stiff
☐ Sharp	☐ Tingling
☐ Shooting	☐ Throbbing
☐ Dull	☐ Swelling
☐ Achy	☐ Numb

How and when did this ailment begin?: _____

Complaint #4:_____ Side: _____

What makes the above region feel worse?:_____ _____

What makes the above region feel relief?: _____

What time of day are your symptoms worst?: _____

What percentage of your day is this pain present: _____ Pain Intensity (0= no pain, 10= worst imaginable pain): _____

Which of the following describes the quality of your pain: ↓

☐Burning	☐ Stiff
☐ Sharp	☐ Tingling
☐ Shooting	☐ Throbbing
☐ Dull	☐ Swelling
☐ Achy	☐ Numb

How and when did this ailment begin?: _____

Surgical History (Please provide procedure name s and years):_____

_____

Medial History (please mark past, present or both):

	PAST	PRESENT	BOTH	Fathers Medical History	Mothers Medical History
Diabetes Type 1	☐	☐	☐	☐	☐
Diabetes Type 2	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Heart Disease or Heart Attack	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Abnormal Weight Loss/Weight Gain	☐	☐	☐	☐	☐
Abdominal Pain	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐
Visual Disturbances	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Systemic Lupus Erythematosus	☐	☐	☐	☐	☐
Dermatitis/Eczema/Rash	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Heart Arrhythmia	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Drug or Alcohol Dependence	☐	☐	☐	☐	☐

Do you have any known issues with bowel or bladder function? ☐ Yes ☐ No

Do you have any visual disturbances? ☐ Yes ☐ No

Night sweats or unexplained weight loss? ☐ Yes ☐ No

What is your occupation?: _____

Daily activities?: _____

What position(s) do you sleep in?:_____

What other specialists do you see?: _____

Anything special we need to know?: _____

Are your ailments related to a motor vehicle accident (MVA) or Workmen's Compensation Claim (that is still open/billable)?

☐ Yes, a motor vehicle accident ☐ Yes, a workmen's compensation injury ☐Neither