Confidential Patient Information

Name: _____ Cell Phone: _____ Hm/Wk Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Age _____ Marital Status (circle one) M S D W

E-mail Address _____

Occupation: _____ Employer: _____

Spouse's Name: _____ # of Children: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes ☐ No ☐ Date: _____

Is this injury/illness related to: Automobile Accident ☐

Date/Time: _____ Location: _____

Your Auto Insurance Co: _____ Phone: _____

Third Party Auto Insurance Co: _____ Phone: _____

Due to changes in health insurance fees, patient self billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you. Ask our front desk associate for more details.

All charges are due when services are rendered…

Method of payment: ( ) Check ( ) Cash ( ) Credit Card

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

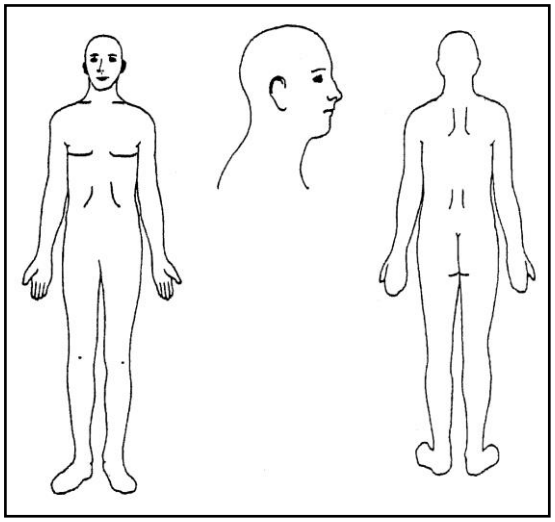
Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

I authorize Advanced Chiropractic to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

CURRENT COMPLAINT: MARK AN X ON THE PICTURE WHERE YOU HAVE THIS PAIN OR DISCOMFORT.



WHEN DID YOUR SYMPTOM FIRST APPEAR?

_____

WHAT CAUSED THIS OR HOW DID YOU DO IT?

_____

EXPLAIN IF YOU FELT OR HAD THIS SYMPTOM BEFORE?

_____

WHAT MAKES THIS SYMPTOM FEEL WORSE?

_____

WHAT MAKES THIS SYMPTOM FEEL BETTER?

_____

List other Chiropractic or Medical Doctors you have consulted for your condition.

1. _____

2. _____

TYPE OF PAIN OR DISCOMFORT:

☐ SHARP ☐ DULL ☐ ACHE ☐ NUMBNESS ☐ SHOOTING ☐ TIGHT ☐ BURNING ☐ TINGLING

☐ SWELLING ☐ STABBING ☐ ITCHING ☐ THROBBING ☐ OTHER _____

OVERALL FREQUENCY OF COMPLAINT:

☐ CONSTANT 100% OF THE TIME ☐ FREQUENT 75% ☐ INTERMITTENT-50% ☐ OCCASIONNAL-25%

CIRCLE THE SEVERITY OF YOUR PAIN AT ITS BEST AND AT ITS WORST.
USE THE SCALE OF ZERO (NO PAIN) TO 10 (SEVERE PAIN).

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

How does this symptom affect you at:

Home/Sleep _____ Work _____ Play/Hobby/Sport _____
Driving/Sitting _____ School _____ Where do you feel your stress _____

For Women:

Is there a chance you are Pregnant? ☐ No ☐ Yes ☐ Not sure! How many weeks? _____
Are you nursing? ☐ No ☐ Yes Do you have breast implants? ☐ No ☐ Yes

HEALTH HISTORY: Please check each of the conditions that you have now or had in the past:

☐ AIDS / HIV	☐ Dizziness / Vertigo	☐ Loss of Sleep	☐ Shingles
☐ Allergies	☐ Epilepsy	☐ Lower Back Problems	☐ Shoulder Pain/Tingling
☐ Arm Pain/Tingling	☐ Feet Pain/Tingling	☐ Mid Back Problems	☐ Stroke
☐ Asthma	☐ Hand Pain/Tingling	☐ Migraines	☐ Tumors/Growths
☐ Bleeding Disorders	☐ Headaches	☐ Multiple Sclerosis	☐ Pain that wakes you up at night
☐ Cancer	☐ Heart Attack/Stroke	☐ Neck Pain	☐ Previous Motor Vehicle Accident(s)
☐ Constipation	☐ High/Low Blood Pressure	☐ Numbness_____	☐ Other _____
☐ Depression	☐ Herniated Disk	☐ Osteoporosis/Osteopenia	
☐ Diabetes	☐ Irritable Bowel	☐ Parkinson's Disease	
☐ Digestive Problems	☐ Jaw Pain	☐ Sciatica	

Injuries/Surgeries you have had:

	Description	Date
Significant Falls	_____	_____
Head Injuries	_____	_____
Broken Bones/Dislocations	_____	_____
Surgeries	_____	_____

Lifestyle Habits:

Tobacco (#/day) _____ Coffee (cups/day) _____ Sleep (hrs/day) _____ Water (oz/day) _____

Alcohol (drinks/day) _____ Tea (cups/day) _____ Soft Drinks (cans/day) _____ ☐ Diet or ☐ Regular

Exercise: Type _____ Frequency _____

_____ _____

FAMILY HISTORY: Please tell us about the major health conditions of your immediate family.

Family Member Relation:	Health Problem:
_____	_____
_____	_____

MEDICATIONS TAKEN NOW: List prescription, OTC, vitamins, minerals, herbs & supplements etc.

Name:	Purpose:	How Long Taken?:
_____	_____	_____
_____	_____	_____
_____	_____	_____

THANK YOU FOR ALLOWING US TO SERVE YOU!

Two-In One- Statement

1. Health Insurance Portability and Accountability Act (HIPAA)

We are required by state and federal law to maintain the privacy of your patient file and the health-protected information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. You have the right, at any time, to review and receive a copy of our complete HIPAA Notice which is available for your viewing.

2. Informed Consent

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and costo-vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. Our doctors will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to their attention, it is your responsibility to inform the doctor.

I have read, or have had read to me, the above statements and by signing below I agree to the above and accept the risks and consequences of their application. I intend this form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at Advanced Chiropractic.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctors of Chiropractic at Advanced Chiropractic and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctors of Chiropractic at Advanced Chiropractic.

_____

Print Patient's Name

_____ _____

Signature of Patient or Representative **Date Signed**