DATE:_____
NAME_____
_____
First Name MI
Last
SEX_____ **HEIGHT**_____ **WEIGHT**_____ **AGE**_____
BIRTHDATE_____

ADDRESS_____**CITY**_____
_____**STATE**_____**ZIP**_____

Home Ph:_____**Work Ph:**_____**Cell Ph:**_____ **Email:**_____

Contact Preference: Home Ph____ Work Ph____ Cell Ph____ **SOCIAL SECURITY #**_____

Language:
___English___Spanish___Indian___Japanese___Chinese___Korean___French___German___Russian_____Other

Race/Ethnicity:___White___American Indian or Alaska Native___Asian___Native Hawaiian/Other Pacific Islander___Black or African American___Hispanic or Latino___Decline to Answer

MARITAL STATUS_____ **NAME OF SPOUSE**_____
OCCUPATION_____

EMPLOYER_____***ADDRESS***_____
_____ ***HOW LONG*****?** _____

NAME OF *SPOUSES EMPLOYER*, ADDRESS & PHONE#_____

HOW WHERE YOU REFERRED TO OUR CLINIC?
_____

LIST YOUR COMPLAINT(S) & GIVE GRADE: MILD (1) MODERATE (2) SEVERE (3) DATE OF ONSET

1._____

_____

2._____

_____

3._____

_____

COMPREHENSIVE DESCRIPTION OF CAUSE (accident, injury, etc.) AND DATE

_____

_____

_____

_____

WHAT POSITIONS OR MOVEMENTS AGGRAVATE YOUR COMPLAINT(S)?

_____

_____

_____

_____

HOME HEALTH CARE & EFFECT

_____

_____

_____

_____

LIST DOCTORS CONSULTED FOR THIS CONDITION:

1. NAME_____
ADDRESS_____
___

SPECIALTY_____ **DATES**_____
RESULT: GOOD_____ FAIR_____ POOR_____

DAIGNOSIS &

TREATMENT_____

_____

_____

_____

_____

_____

_____

_____

2. NAME_____
ADDRESS_____
__

SPECIALTY_____ **DATES**_____
RESULT: GOOD_____ FAIR_____ POOR_____

DAIGNOSIS &

TREATMENT_____

_____

_____

_____

_____

_____

_____

Date:_____
_____
First Name **MI**
Last Name

Are you seeing any other providers for other problems or health conditions? YES or No (Please Circle)

Please list the problems(s), date problem(s) began and Provider(s) treating you for the condition(s):

_____

_____

_____

_____

_____

Past History

Have you -- If Yes, Please list the date and the name of the treating provider.

ever been diagnosed with hypertension? Yes or No

_____

been hospitalized in the last 5 years? Yes or No

_____

been diagnosed with Diabetes? Yes or No

_____ ___Type I ___Type II

Do you smoke? ____Never ____Former Smoker ____Current/Every Day Smoker ____Current Some Day[s] Smoker

Vitals (for office use only) Height _____ Weight _____ Blood Pressure _____

Medications

What medications are you currently taking? Please include all non-prescription and over the counter vitamins, herbs, minerals, etc.: List date Started, Brand Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by: Please be as specific as possible.

_____

_____

_____

_____

_____

_____

Do you have allergies? ____Food ____Environmental ____Medication

List Type of Allergy and Reaction[s]

_____

_____

_____

_____

_____

_____

Thank You for Your Cooperation

LIST ALL MEDICATIONS & NUTRITIONAL SUPPLEMENTS CURRENTLY BEING TAKEN _____

PLEASE GRADE ANY OF THE FOLLOWING PROBLEMS YOU HAVE HAD. MILD (1) MODERATE (2) SEVERE (3

WRITE PAST &/OR PRESENT TO THE RIGHT OF THE PROBLEM.

1	2	3	GENERAL
			Allergy
			Chills
			Convulsions
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Loss of sleep
			Loss of weight
			Nervousness/depression
			Neuralgia
			Numbness
			Sweats
			Tremors
			MUSCLE & JOINT
			Arthritis
			Bursitis
			Foot trouble
			Hernia
			Low back pain
			Lumbago
			Neck pain or stiffness
			Pain between shoulders
			Pain or numbness in:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Legs
			Knees
			Feet
			Painful tail bone
			Poor posture
			Sciatica
			Spinal curvature
			Swollen joints

1	2	3	GASTRO-INTESTINAL
			Belching or gas
			Colitis
			Colon trouble
			Constipation
			Diarrhea
			Dificult digestion
			Distension of abdomen
			Excessive hunger
			Gall bladder trouble
			Hemorrhoids
			Intestinal worms
			Jaundice
			Liver trouble
			Nausea
			Pain over stomach
			Poor appetite
			Vomiting
			Vomiting of blood
			EYES, EARS, NOSE & THROAT
			Asthma
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Earache
			Ear discharge
			Ear noises
			Enlarged glands
			Enlarged thyroid
			Eye pain
			Failing vision
			Far sightedness
			Gum trouble
			Hay fever
			Hoarseness
			Nasal obstruction
			Near sightedness
			Nosebleeds
			Sinus infection
			Sore throat
			Tonsillitis

1	2	3	CARDIO-VASCULAR
			Hardening of arteries
			High blood pressure
			Low blood pressure
			Pain over heart
			Poor circulation
			Rapid heart beat
			Slow heart beat
			Swelling of ankles
			RESPIRATORY
			Chest pain
			Chronic cough
			Difficult breathing
			Spitting up blood
			Spitting up phlegm
			Wheezing
			SKIN
			Boils
			Bruise easily
			Dryness
			Hives or allergy
			Itching
			Skin eruptions (rash)
			Varicose vains
			GENITO-URINARY
			Bed wetting
			Blood in urine
			Frequent urination
			Inability to control kidneys
			Kidney infection or stones
			Painful urination
			Prostate trouble
			Pus in urine
			FOR WOMEN ONLY
			Congested breasts
			Cramps or backache
			Excessive menstral flow
			Hot flashes
			Irregular cycle
			Menopausal symptoms
			Painful menstration
			Vaginal discharge
	Yes		No Are you pregnant?

INDICATE ANY FAMILY MEMBER/RELATIVE WHO HAS HAD THE FOLLOWING: CANCER _____

DIABETES_____ HEART ATTACK_____ HIGH BLOOD PRESSURE_____ STROKE_____

MUSCLE-SKELETAL PROBLEMS (recurrent sprains, scoliosis, severe arthritis, etc.) EXPLAIN: _____

Insurance Information: A copy of your insurance card[s] will be made, in addition, please complete the inform

Are you the policy holder? YES or NO If No, who is? ____Spouse ____Parent ____Employer Other_____

_____

Policy Holder's First Name MI Last Name DO

Policy Holder's Social Security #: _____Policy Holder's Employer_____

Do you have secondary insurance? YES or NO? If yes, please complete the followi

_____

Policy Holder's First Name MI Last Name DO

Policy Holder's Social Security #:_____ Policy Holder's Employer:_____

Information About Advanced Health PA Privacy And Financial Policies

Our Financial Policy:

I authorize release of necessary medical records, and benefit payment to the clinic. The clinic will aid in processing of insurance claim forms. This account remains my responsibility, including 2% interest per month added to overdue accounts - $2.00 minimum. Patient will be responsible for collection agency fees up to 35% of the outstanding balance as well as any court cost and legal fees necessary to collect the debt. I understand I have only received an estimate of charges. Further, I understand that missed appointments not canceled at least 24 hours in advance will result in a fee of $50.00.

Authorization for Minors (under 18 years old)

I _____ authorize the examination and treatment of _____ at

Advanced Health PA. SIGNED_____ DATE_____

(Guarantor)

OUR PRIVACY POLICY

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detail the Practice's legal duties and privacy practices with respect to your PHI

(b) Under the Privacy Rule, may be required by State law to grand greater access or maintain greater restrictions the use or release of your PHI than that which is provided for under federal la

(C) I required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementati

(f) Will not retaliate against you for filing a complaint.

Informed Consen

I have been explained my condition or what is know about it presently.

I have been explained the benefits and risks of chiropractic adjustments

I have been informed of my treatment options

Patient Acknowledgement

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____

Patient

_____

Date