

## Welcome To Our Office

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE LIST YOUR PRIMARY COMPLAINTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IS THIS INJURY THE RESULT FROM ONE OF THE FOLLOWING:** (circle one)  
 WORK INJURY    AUTO INJURY    SPORTS INJURY    OTHER: \_\_\_\_\_  
 SLIP/FALL    TRAUMA    ILLNESS    UNKNOWN

**WHAT DAY DID THIS INJURY START TO OCCUR:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**HAVE YOU HAD THIS SIMILAR CONDITION IN THE PAST?** YES or NO    **How Frequent:** \_\_\_\_\_

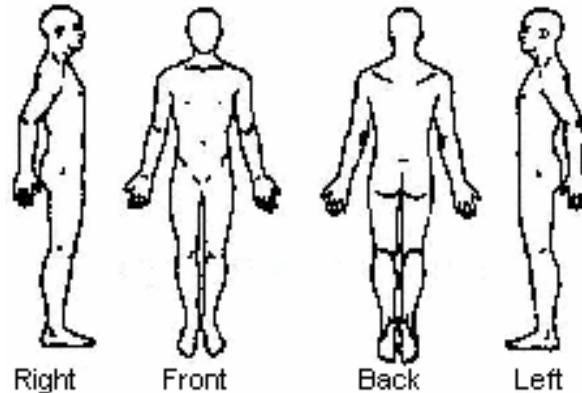
**HOW LONG HAVE YOU EXPERIENCED THIS FOR?** (be specific): \_\_\_\_\_

**IS YOUR COMPLAINT GETTING** (circle one): Better / Worse / The Same

**ON A SCALE OF 1 TO 10**

**Please mark below where you are experiencing pain:**

WHAT IS YOUR CURRENT PAIN :  
 1   2   3   4   5   6   7   8   9   10  
 IN THE PAST MONTH, WHERE IS YOUR PAIN:



**AT ITS BEST** \_\_\_\_\_  
**AT ITS WORST** \_\_\_\_\_

**IS YOUR PAIN:** Constant    Comes and Goes  
 Worse at Night    Worse during the day

**Types of Pain:**

- \_\_\_ Sharp    \_\_\_ Dull
- \_\_\_ Throbbing    \_\_\_ Numbness
- \_\_\_ Aching    \_\_\_ Shooting
- \_\_\_ Burning    \_\_\_ Tingling
- \_\_\_ Cramping

**What is the pain Aggravated by?**

- \_\_\_ Sitting    \_\_\_ Standing
- \_\_\_ Laying Down    \_\_\_ Sneezing
- \_\_\_ Walking    \_\_\_ Coughing
- \_\_\_ Bowel Movement    \_\_\_ Standing
- \_\_\_ Sleeping    \_\_\_ Bending
- \_\_\_ Computer Work    \_\_\_ Driving
- Other: \_\_\_\_\_

**What relieves your pain?**

- Ice    Heat
- Rest    Massage
- Exercise    Stretching
- Pain Meds    Other: \_\_\_\_\_

**WHAT MAKES IT : BETTER** \_\_\_\_\_ **and** **WORSE:** \_\_\_\_\_

**WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH CHIROPRACTIC CARE?**

- Relief Care     Corrective Care     Wellness/Prevention     Other



**CURRENT/PAST HEALTH HISTORY:**

WHO IS YOUR PRIMARY CARE PHYSICIAN?: \_\_\_\_\_

HAVE YOU RECEIVED TREATMENT FROM OTHER DOCTORS?: (Who and When?) \_\_\_\_\_

HAVE YOU HAD ANY MAJOR ACCIDENT OR FALLS, SURGERIES OR HOSPITALIZATIONS?: \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING DISEASES YOU HAVE/HAD:**

Rheumatic Fever   Mumps   Pleurisy   Measles   Epilepsy   Cancer   Thyroid   Tuberculosis   Anemia   Eczema  
 Whooping-Cough   Small Pox   Diabetes   Polio   Mental Disorders   Heart Disease   Pneumonia   Arthritis   Other: \_\_\_\_\_

**MUSCLO-SKELETAL**

\_\_\_ Low Back Pain  
 \_\_\_ Pain Between Shoulders  
 \_\_\_ Neck Pain  
 \_\_\_ Arm Pain  
 \_\_\_ Joint Pain/ Stiffness  
 \_\_\_ Walking Problems  
 \_\_\_ Difficult Chewing/Clicking Jaw

**NERVOUS SYSTEM**

\_\_\_ Nervous  
 \_\_\_ Numbness  
 \_\_\_ Dizziness  
 \_\_\_ Forgetfulness  
 \_\_\_ Confusion  
 \_\_\_ Depression  
 \_\_\_ Cold/Tingling Extremities

**GASTROINTESTINAL**

\_\_\_ Poor/Excessive Appetite  
 \_\_\_ Excessive Thirst  
 \_\_\_ Diarrhea or Constipation  
 \_\_\_ Hemorrhoids  
 \_\_\_ Weight Trouble  
 \_\_\_ Heartburn  
 \_\_\_ Black/Bloody Stool

**CV-R**

\_\_\_ Chest Pain  
 \_\_\_ Short Breath  
 \_\_\_ Heart Problems  
 \_\_\_ Ankle Swelling  
 \_\_\_ Stroke

**MALE/FEMALE**

\_\_\_ Menstrual Irregularity  
 \_\_\_ Menstrual Cramps  
 \_\_\_ Breast Pain / Lumps  
 \_\_\_ Prostate Dysfunction

**FEMALES ONLY**

Are You Pregnant?  
 Yes      No  
 If yes, what is your  
 Due Date: \_\_\_\_\_

**FAMILY HISTORY**

Have the following had the  
 same/similar symptoms?:  
 \_\_\_ Mother  
 \_\_\_ Father  
 \_\_\_ Brother  
 \_\_\_ Sister

**GENERAL**

\_\_\_ Fatigue  
 \_\_\_ Allergies  
 \_\_\_ Loss Of Sleep  
 \_\_\_ Fever  
 \_\_\_ Headache

<p align="center"><b><u>Exercise:</u></b></p> <p>___ None          ___ Moderate          ___ Daily          ___ Heavy          Do You Stretch? ___ Yes ___ No</p>	<p align="center"><b><u>Work Activity</u></b></p> <p>___ Sitting          ___ Standing          ___ Light Labor          ___ Heavy Labor          ___ Computer Work          Do you like your job? ___ Yes ___ No</p>	<p align="center"><b><u>Habits</u></b></p> <p>___ Smoking      Pack/Day _____          ___ Alcohol      Drinks/Week _____          ___ Coffee/Pop    Cups/Day _____          ___ Sugar            Per Day _____          ___ Stress            Reason: _____</p>
<p align="center"><b><u>Medications:</u></b></p> <p>_____          _____          _____</p>	<p align="center"><b><u>Allergies:</u></b></p> <p>_____          _____          _____</p>	<p align="center"><b><u>Vitamins/Herbs/Minerals:</u></b></p> <p>_____          _____          _____</p>



**Patient Information Sheet**

*(Please Print Clearly)*

Patient Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: (     ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

Marital Status: M \_\_\_\_\_ S \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Email Address: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Do you have children? Yes \_\_\_\_\_ No \_\_\_\_\_ What are their names and ages? \_\_\_\_\_

Who referred you to our office? Friend/Family Member: \_\_\_\_\_

\_\_\_\_ Health Screening - Which One? \_\_\_\_\_ Curves Other: \_\_\_\_\_

\_\_\_\_ Health Pass    \_\_\_\_ Newspaper    \_\_\_\_ Mailing    \_\_\_\_ Sign    \_\_\_\_ Insurance Provider Listing

Occupation:	Employer:
Address:	Phone:
<b><u>Emergency Contact:</u></b>	<b><u>Phone:</u></b>

<b>Primary Insurance:</b>	Relationship to Patient:
ID #:	Group #:
<b>Secondary Insurance:</b>	Relationship to Patient:
ID #:	Group #:

**Assignment of Benefits / Release of Information:**

I authorize payment of insurance benefits directly to Advanced Healthcare Associates. I authorize the doctor to release any information to any parties necessary to secure the payment of benefits and request medical information from any source necessary in order to provide the proper quality of care and to secure payment for services. I agree to be financially responsible for all charges incurred to Advanced Healthcare Assoc. including my insurance deductible, co-payment, and services not covered by my insurance company or paid in full through any settlement or court case. Any remaining balance I will pay in full per the policies of Advanced Healthcare Assoc. I consent to receive treatment by Advanced Healthcare Assoc. I have also read and understand the privacy policies of Advanced Healthcare Associates and my privacy rights under those policies.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date