Advance Chiropractic Center

Name_____ Date_____

Address_____ City_____

State_____ Zip_____ E-Mail Address_____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Social Security #_____ Referred by_____

Birth Date___/___/___ Age____ Marital Status: S M D W Name of Spouse_____

Employer_____ Occupation_____

Employer Address_____ Is this a work related injury?_____

Please list any medications you are taking:_____

Please provide the following payment/insurance information:

____ I have no insurance coverage. **I understand that payment in full is expected on each visit.**

I will pay by the following method:

___Cash/Check ___Credit Card

___Blue Cross/Blue Shield

___Other group or private health insurance

___Workers Compensation...Date of Injury_____ State_____

___ND Medical Assistance

___No Fault Auto Insurance...Date of Injury_____

___Medicare....Medicare supplement (If any)_____

***Please note that Medicare (including Medicare replacement policies) does not cover initial exam, therapy or x-rays. All that will be covered is the chiropractic manipulation.

___Other

Insurance Co-Payments are due on each visit

___I am a student. Please send billings to insurance policy holder.

Name and Address_____

**Do you have more then one insurance? If so, please read on. If you have more than one insurance policy, it may take a while for both insurance companies to process the claims. Please note that a statement will be sent out monthly, and will not reflect any secondary insurance that may be pending. You will want to check your explanation of benefits to see what has cleared your secondary insurance. You may also call with any questions you may have.

I understand that the health and insurance policies are an arrangement between the insurance carrier and myself (or name of insured), and I understand that I am responsible for payment regardless of what insurance covers. I authorize the release of any medical or other information necessary to process this claim, and I authorize payment of medical benefits directly to Advance Chiropractic Center for services rendered. I also authorize Advance Chiropractic Center to administer such treatment and diagnostic procedures as is necessary, and to perform manipulation, therapy and/or procedures considered therapeutically necessary on the basis of the findings during the course of treatment. I understand that treatment carries a risk of complication such as, but not limited to, injury to the vertebral artery, which can cause a stroke or stroke-like occurrence. I also certify that no guarantee has been made as to the results that may be obtained.

_____ _____

Signature **Date**

Advance Chiropractic

Name _____ Date ____/____/____ File # _____

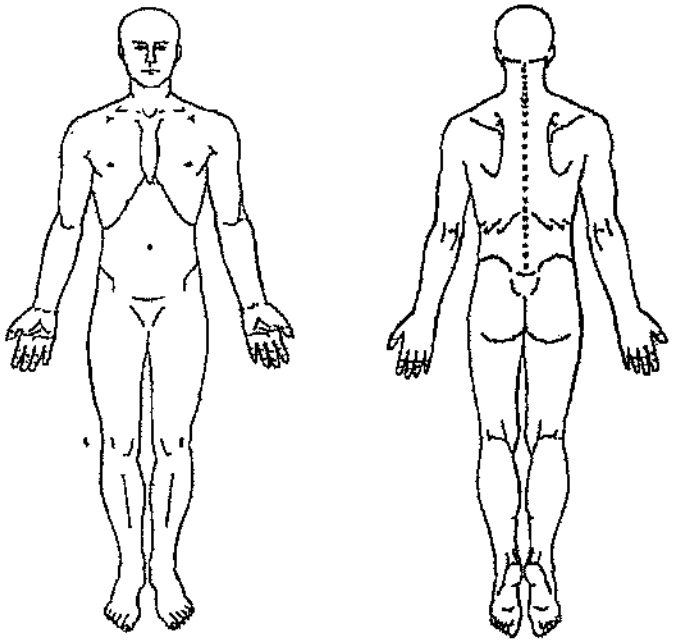
Please describe your health problem(s) or reason(s) for coming to the clinic:

_____

Have you had any previous treatment for this problem? ☐ No ☐ Yes → Please describe and give dates:

_____

If you are suffering from pain, please draw the location(s) on the body diagrams below:



Please rate the extent of your pain or ache by circling a number below:

No pain

0
1
2
3
4
5
6
7
8
9
10

Unbearable Pain

Please describe the pain: _____

When and how did this problem start? _____

Does anything make it worse (lifting, coughing, etc)? _____

Does anything make it better (heat, rest, aspirin, etc)? _____

When is the problem most apparent? (Check all that apply) ☐ Morning ☐ Day ☐ Night

Does it affect work/school? ☐ No ☐ Occasionally ☐ Frequently ☐ Constantly

Does it affect your sleep? ☐ No ☐ Occasionally ☐ Frequently ☐ Constantly

This problem/condition is.... ☐ Getting worse ☐ Staying the same ☐ Improving

Have you had any other symptoms? ☐ No ☐ Yes → Please describe: _____

_____

PATIENT NAME _____

DATE _____ Doctor_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____

Do you have a history of stroke or hypertension?_____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:_____

Do you have any Congenital Condition? ___Yes ___ No If YES, Describe _____

Women: Are you pregnant?_____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter N if you have these conditions **now** or **P** if you have had these conditions **previously.**

	N = Now	P = Previously	
Headaches_____ Frequency	_____	Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____

PATIENT NAME _____

DATE _____ Doctor_____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing In Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alchoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Depression	_____
Ulcers	_____		

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify)_____

_____

_____

PATIENT NAME _____

DATE _____ Doctor_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
HighBlood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____