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:_____

Allergies:_____

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.

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 Clinic

Name _____ Date ____/____/____ File # _____

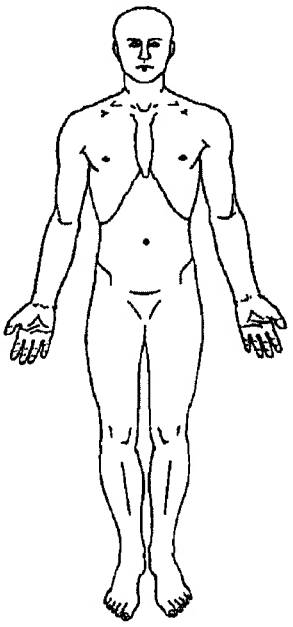
Please describe your health problem(s) or reason(s) for coming to the clinic:

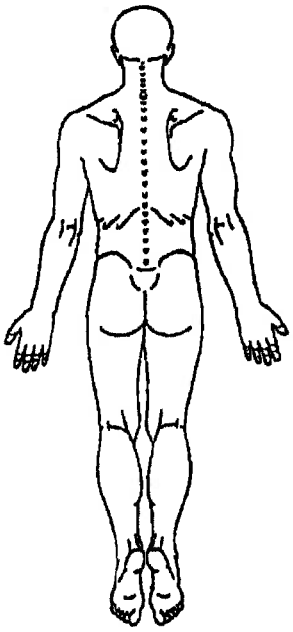
_____

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: _____

_____

Height_____ Weight _____ Circle one: Right Handed / Left Handed

Medical History Form

Name:_____ **Today's Date**: _____

Reason you are here:_____

Date Of Onset: _____

Personal Medical History: Have you ever had any of the following conditions? (Check if yes)

☐ Headaches (Frequency _____)	☐ Dizziness	☐ Unusual Bowel Patterns
☐ Neck pain	☐ Shoulder/ Neck / Arm pain	☐ Arthritis
☐ Sleeping Problems	☐ Numbness in fingers	☐ Muscle Spasms
☐ Back Pain	☐ Numbness in toes	☐ Frequent Colds
☐ Nervousness	☐ Loss of Balance	☐ Frequent Fevers
☐ Tension	☐ Fainting	☐ Frequent Sinus Problems
☐ Irritability	☐ Loss of Smell	☐ Eating Disorder
☐ Chest Pain / Tightness	☐ Loss of Taste	☐ Drug Addiction
☐ High Blood Pressure	☐ Broken / Fractured Bones	☐ Gallbladder Problems
☐ Difficulty Urinating	☐ Rheumatoid Arthritis	☐ Ulcers
☐ Weakness in Extremities	☐ Excessive Bleeding	☐ Diabetes
☐ Breathing Problems	☐ Osteoarthritis	☐ Indigestion Problems
☐ Fatigue	☐ Pacemaker	☐ Joint Pain / Swelling
☐ Sensitivity to Lights	☐ Stroke	☐ Alcoholism
☐ Ears Ringing or Buzzing	☐ Ruptures	☐ HIV Positive
☐ Weight Loss / Gain	☐ Heart Disease	☐ Circulation Problems
☐ Depression	☐ Cancer	☐ Seizures / Epilepsy
☐ Loss of Memory	☐ Coughing Up Blood	☐ Low Blood Pressure
☐ Are you Pregnant?	☐ Congenital Conditions (Explain)	☐ Osteoporosis
	----------	☐ Allergies _____

Social History: Check if you engage in any of the following

☐ No Exercise	☐ Alcohol Use	☐ High Stress Activity
☐ Moderate Exercise	☐ Drug Use	☐ Family Pressures
☐ Vigorous Exercise	☐ Caffeine Consumption	☐ Financial Pressures
		☐ Other Mental Stressers_____
		☐ Other_____

Family History: Has anyone in your family had any of the following conditions? (Check if yes, and indicate relationship to you)

☐ Arthritis_____	☐ Emphysema _____	☐ Migraine_____
☐ Asthma-Hay Fever_____	☐ Epilepsy_____	☐ Nervousness_____
☐ Back Trouble_____	☐ Headaches_____	☐ Neuritis _____
☐ Bursitis _____	☐ Heart Trouble _____	☐ Neuralgia_____
☐ Cancer_____	☐ High Blood Pressure_____	☐ Pinched Nerve_____
☐ Constipation_____	☐ Insomnia_____	☐ Scoliosis _____
☐ Diabetes_____	☐ Kidney Trouble_____	☐ Sinus Trouble_____
☐ Disc Problem_____	☐ Liver Trouble_____	☐ Stomach Trouble_____
		☐ Other_____