

Patient Name _____ Address _____



City _____ State _____ Zip code _____ E-mail _____

Home# _____ Work# _____ Cell# _____

Which phone number and time is best to reach you? _____

Date of Birth _____ Social Security Number _____ Gender: M F

To better serve you please answer the following questions:

1. What are your health goals? _____

2. How do you expect to achieve them? _____

3. Addressing what brought you into this office:

(If you have no symptoms or complaints and are here for wellness services, please skip to question 5.)

Please list your health concerns according to their severity	Rate of severity 1=mild 10=worst imaginable	When did this Episode start?	If you had this Condition before, When?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

4. Check off the following symptoms or disorders you have and CIRCLE the ones that affect you the most

- | | | | |
|---------------------------|-------------------------------|-------------------------------|--------------------------|
| Headache/Migraines | Neck Pain | Hip pain (right or left) | Chemical Stress |
| Sinus/Allergies | Shoulder pain (right or left) | Knee pain (right or left) | Physical Stress |
| Chest/Rib pain | Elbow pain (right or left) | Ankle pain (right or left) | Emotional Stress/Anxiety |
| Dizziness | Wrist pain (right or left) | Muscle Stress | Attention Disorders |
| Ear Aches | Scoliosis | Constipation | Sciatica |
| Asthma | Low Back pain | Hyperactivity | Numbness/Tingling |
| Frequent colds/flu | Mid-back Pain | Arthritis | Leg pain (right or left) |
| Heartburn/Reflux | Disc Problems | Stomach Problems | Arm pain (right or left) |
| Low energy/Tired /Fatigue | Insomnia | Depression | Vertigo |
| Unexpected Weight Gain | Ringin/Buzzing in Ears | Bed Wetting | Ulcers |
| Loss of Memory | High Blood Pressure | Menstrual Problems | Autoimmune Disease |
| Excess Gas/Bloating | Low Blood Pressure | Thyroid Trouble | Diabetes |
| Multiple Sclerosis | Fibromyalgia | Blood Circulatory Problems | Swollen Ankles |
| High Cholesterol | Shortness of breath | Nausea | Skin Conditions/Acne |
| Bladder Problems | Cancer | Circulatory/Vascular Disorder | Diarrhea |
| Digestive Problems | Indigestion | Heart Condition | Immune System Disorder |
| Infertility | Kidney Disease | Mood Swings | |
| Osteoporosis | Sinus Trouble | Urinary Difficulty | |
| Other: _____ | | | |

*******Vertebral Subluxations can cause your pain*******

Which pain or condition you have marked is the **worst** for you? _____

How long has it bothered you? _____

Is your pain **sharp** or **dull**? _____

Subluxations can put pressure on the spinal cord which can be constant or occasional. Which do you feel? _____

Pressure on the spinal cord or nerves can be **worse** in the **AM** or the **PM**. Which one is harder for you? _____

Does this radiate into an extremity or stay in one area? _____

5a. Are any of the above symptoms linked to a current car accident or workers compensation case? _____

6. Please indicate which aspects of your life are compromised by your current level of health:

- | | | |
|-----------------|-------------------------|----------------------|
| Bending | Sleeping | Housework |
| Lifting | Lying in Bed | Yardwork |
| Walking | Lifting Children | Travel |
| Sitting | Sports | Grooming |
| Climbing Stairs | Recreational Activities | Job Activities |
| Standing | Getting in/out of Car | Emotional Well-Being |
| Running | | |
| Exercise | | |

7. a. Do you have trouble with? (Check what applies)

___Anxiety ___Depression ___Irritability

8. On a 1-10 scale,

- a. Where would you rate your overall health and well-being? _____
- b. Where would you want it to be? _____ And how long do you think this process will take? _____

9. Have you had any experience with chiropractic? YES NO

- a. Did you like the results? YES NO
- b. What did you enjoy most and least about your visits there? _____

How were you referred to us _____
Employer _____

Occupation (Please be specific. Often times the work that we do greatly affects our health and/or stress level. This information will help the doctor with your course of care). _____

Circle one: Single Married Divorced/Separated Widow/ed

Name of Spouse _____

Name of children and age(s) _____

Education completed: High school College Graduate Post-Graduate

Advanced Chiropractic Healthcare

Patient Name: _____

Medical History

List all physicians and practitioners you have seen for your **current** condition _____

Have you had any surgeries? YES NO If so, when and what? _____

Do you have any scars? YES NO If yes, where? _____

Do you currently have any injuries as a result of an auto or work related accident. If yes, please specify. _____

Have you ever been hospitalized? YES NO If yes, list reason _____

List any medical conditions you currently have _____

List any medications you are currently on _____

If there was a way we can help you come off these medications would you be interested? YES NO

List any known allergies (food, inhalants, etc.) _____

Have you ever had any of the following diagnostic tests?

___X-rays ___MRI scans ___Bone scan ___CT scan

___Myelogram ___Disco gram ___EMG

If any selected, list reason: _____

Do you have a history of cancer? YES NO

Are you currently pregnant? YES NO

Check all that apply:

___Smoker ___Non-smoker ___Drinks Alcohol ___Does not drink alcohol ___Takes drugs ___Does not take drug

SOCIAL/FAMILY MEDICAL HISTORY

Heart Disease Stroke Circulatory Disorder Blood Pressure Diabetes

Other: _____

Advanced Holistic Healthcare
901 Stewart Ave., Ste. 285 ~ Garden City, NY 11530
(516) 742-5715 ~ Fax (516) 742-1740

Informed Consent:

I do hereby authorize the doctors of Advanced Chiropractic Healthcare to administer such care that is necessary for my particular case. This may include consultation, examination, adjustments or any other procedure, which is advisable and necessary for my healthcare.

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Advanced Chiropractic Healthcare, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

I understand that payment plans are mandatory unless balance can be paid in full. Finance charges will be applied to balances 60 days overdue at 1.5% and every 30 days there after.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of seven percent (7%) per annum. I further acknowledge and agree that Advanced Holistic Healthcare shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Advanced Holistic Healthcare.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Advanced Chiropractic Healthcare, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Acknowledgement

I have been informed that upon request I can receive a copy of the privacy practices (HIPPA)
and I am aware that I have an opportunity to discuss my rights to privacy if I please.

Print Name: _____

Signature: _____ Date: _____

******FOR WOMEN ONLY******

Pregnancy Release:

This is to certify that to the best of my knowledge **I am NOT pregnant** and the above and doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can harm a fetus (unborn child) in the early stages. **Date of last menstrual period:** _____

Signature: _____ **Date:** _____

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Print Name: _____

Signature: _____ Date: _____

Communications:

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: _____ Children: _____ Others: _____