Welcome to Advanced Chiropractic Specialists

Confidential Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. Make sure you complete both sides and sign your name on the back. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

Date ______________________ e-mail Address: ______________________ Cell Phone ______________________

Name ______________________ (First, Middle, Last) Sex _____ (M or F) Marital Status _____ D.O.B. _______ (Mo/Day/Yr) Age____ Home Phone ______________________ (Area Code/Number)

Address ______________________ (Include Street type such as St., Ave., etc.) City ______________ State _______ Zip Code ___________

Social Security # ____ Business Phone Number ____ Company Name ____ Location ____

Spouse's First Name ____ Spouse's Social Sec # ____ Spouse's Employer ____ Location ____

Name of nearest relative (not living with you): ______________________ Phone: ______________________

Whom may we thank for referring you to us? ______________________

Were you referred to a certain doctor in this office? ______________________

Is your visit due to an accident? ☐ No ☐ Yes, Date __________ (If yes, please see receptionist for an injury report.)

My bill will be paid by: ☐ Cash ☐ Medicare ☐ Worker's Compensation ☐Attorney Lien ☐ Health Insurance ☐ Other Ins.

Insurance Company______________________ Group/Policy No. ______________________

Responsible Party and/or Primary Insured: Name ______________________ (First, Middle, Last) D.O.B _________ (Mo/Day/Yr)

Social Security # ______-_____-_________ Home Phone ______________ (Area Code/Number) Cell Phone ______________ (Area Code/Number)

Address ______________________ (Include Street type such as St., Ave., etc.) City ____________ State ________ Zip _________

Employer ______________________ Phone ______________ (Area Code/Number)

Reason for visit______________________ When did you first notice the symptoms? ____________

Is this condition getting progressively worse? ______________________

Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other ____________

Type of Pain(s): ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting *(Please complete the*
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other *diagram on other side*.)

Rate the severity of your pain (1, mild pain or discomfort, to 10, severe pain): 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ______________________

List other doctor(s) seen for this condition ______________________

Medical History (if any of the following are relevant to your medical history, please check the accompanying box:)

☐ AIDS/HIV	☐ Pacemaker	☐ Osteoporosis	☐ Stroke
☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussion	☐ Dizziness	☐ Arthritis
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ Venereal Disease

Describe any operations you've had and the dates: ______________________

____

(Please complete both sides.)

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

Describe Condition ______________________________ Date of last physical exam ______________

Are you now taking any medication? ☐ Yes ☐ No What kind? ______________________________

Are you allergic to any medication? ☐ Yes ☐ No What kind? ______________________________

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period:______________________________

Daily Habits

Do you exercise? ☐ No ☐ Yes How often? ______________ What type? ______________________

What do your daily activities and work duties include? (sitting, standing, light work, heavy work, lifting, etc)______________

What vitamins do you currently take? ______________________________

Do you smoke? ☐ No ☐ Yes How much per day? ______________________________

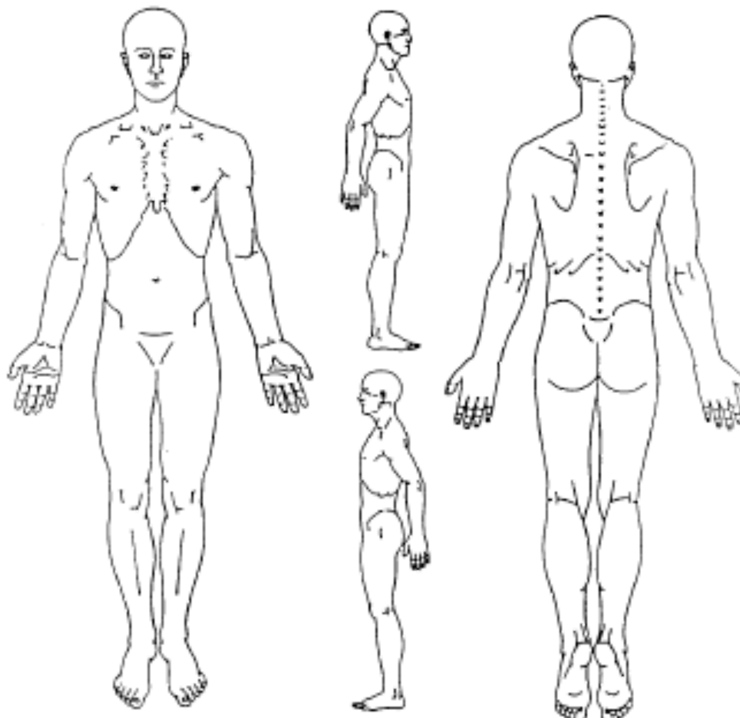
Do you consume alcoholic beverages? ☐ No ☐ Yes How many per week? ______________________

How much coffee or caffeinated beverages do you consume on a daily basis? ______________________

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

(On the diagram below.)

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
▲ ▲ ▲	**XXX**	**= = =**	**OOO**	**/ / /**	**...**



I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Advanced Chiropractic Specialists extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I understand if I default on any portion of the amount owed, I agree to pay any and all reasonable collection fees and attorney fees as prescribed by law. I hereby authorize the doctors at Advanced Chiropractic Specialists and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature ______________________________ **Date**______________