NEW PATIENT HEALTH HISTORY

ADVANCED
FAMILY CHIROPRACTIC CENTER

Two options for completing this form:

- Please fill out this form on your computer, print it out, and bring it with you to your first appointment.
- Please print out this form, then fill it out using a pen, and bring it with you to your first appointment.

Note: Regardless of the completion method selected above, the diagrams on page four require you to complete them using a pen.

Patient Contact Information

Patient's Full Name ______________________________ Sex ❑ F ❑ M Date ______/______/______

Patient's Social Security # ______________________________ Date of Birth ______/______/______ Age __________

E-mail ____

Parent or Guardian's Name (if patient under age 18) ______________________________

Address ______________________________ Apt. (if applicable) ______________

City ______________________________ State ______________ Zip ______________

Home Phone (_______)______________ Work Phone (_______)______________ Cell Phone (_______)______________

Emergency Contact ______________________________ Emergency Contact Phone (_______)______________

Patient's Occupation ______________________________ Employer ______________________________

Patient's Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed If Married, Spouse's Name ______________________

Number of Children ______ Spouse's Occupation ______________________ Spouse's Employer ______________________

Name of Referring Physician, Patient, or Family Member (if applicable) ______________________________

Insurance Coverage Information

Do You Have Health Insurance Coverage? ❑ Yes ❑ No* If yes, please present your health insurance ID card when you arrive at the our office for your first visit. We will make a photocopy of it for our files.

If insured, are you the primary name on the policy or is your spouse? ❑ I am the primary name ❑ My spouse is the primary name

If Spouse, Spouse's Name ______________________________ DOB ______/______/______

Are You Enrolled in ❑ Medicare ❑ Medicaid ? If you have Medicare supplemental insurance, please present your health insurance ID card when you arrive at the our of fice for your first visit. We will make a photocopy of it for our files.

Are you suffering from an auto accident injury that resulted in a claim? ❑ Yes ❑ No If yes, please bring the auto accident claim information received from your insurance agent. We will make a photocopy of it for our files.

* If you do not have health insurance coverage, Advanced Family Chiropractic Center of fers convenient payment plans that fit most budgets.

Reasons for Seeking Chiropractic Care

Chief Complaint (include location) ______________________________

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Secondary Complaint, if any (include location) ______________________________

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Have You Ever Received Chiropractic Care? ❑ Yes ❑ No If Yes, When? ______________________________

Nature of Injury ❑ Automobile ❑ Work ❑ Other ______________________________

Complaint(s) Began When & How? ______________________________

Reasons for Seeking Chiropractic Care (continued)

Description of the Complaint/Pain: ❑ Dull ❑ Aching ❑ Sharp ❑ Shooting ❑ Burning ❑ Throbbing ❑ Deep ❑ Nagging

❑ Other Describe ____

Does This Pain Radiate or Travel (Shoot) to Any Other Areas of Your Body? ❑ Yes ❑ No If Yes, Where? ____________

Do You Have Any Numbness or Tingling in Your Body? ❑ Yes ❑ No If Yes, Where? ______________________

How Frequent Is Complaint Present, How Long Does It Last?______________________________________

Does Anything Aggravate the Pain? ____

Does Anything Make the Pain Better? ____

Medical History

Your Height: _________feet _________inches Your Weight: _________pounds

Previous Care for Your Complaint/Pain (Treatments, Medications, or Surgery You've Sought for Your Complaint) ____________

____

____

Have You Been Treated for Any Conditions in the Last Year? ❑ Yes ❑ No If Yes, What? ______________________

____

Approximate Date of Last Physical Exam______/______/______ Females: Could You Be Pregnant? ❑ Yes ❑ No ❑ Not Sure

Have You Had X-Rays Taken in the Past Three Years? ❑ Yes ❑ No If Yes, Where? ______________________

What Medications Are You Taking and for What Conditions (Please List Dosage and Amounts, etc.) ________________

____

What Vitamins, Minerals, or Herbs Do You Currently Take? (Please List Dosage and Amounts, and for What Condition, etc.) ______

____

Family Member (Mother, Father, etc.) Present and Past Health Conditions (Heart Disease, Cancer, Diabetes, Arthritis, etc.)

1. ____

2. ____

3. ____

Have You Ever: If Yes, Briefly Explain:

Broken Bones ❑ Yes ❑ No ______________________________ ____________

Been Hospitalized ❑ Yes ❑ No ______________________________ ____________

Been in an Auto Accident ❑ Yes ❑ No ______________________________ ____________

Had Sprains/Strains ❑ Yes ❑ No ____

Had a Sports Injury ❑ Yes ❑ No ____

Been Struck Unconscious ❑ Yes ❑ No ______________________________ ____________

Had Surgery ❑ Yes ❑ No ______________________________ ____________

Used a Cane or Walker ❑ Yes ❑ No ____

Medical History (continued)

Have You Ever Suffered from:

❑ Alcoholism	❑ Allergies	❑ Anemia	❑ Arteriosclerosis	❑ Arthritis	❑ Asthma
❑ Back Pain	❑ Breast Lump	❑ Bronchitis	❑ Bruise Easliy	❑ Cancer	❑ Chest Pain
❑ Cold Extremities	❑ Constipation	❑ Cramps	❑ Depression	❑ Diabetes	❑ Digestion Problems
❑ Dizziness	❑ Ears Ring	❑ Eye Pain/Problems	❑ Fatigue	❑ Frequent Urination	❑ Headaches
❑ Hemorrhoid	❑ High Blood Pressure	❑ Hot Flashes	❑ Irregular Heart Beat	❑ Irregular Cycles	❑ Kidney Infection
❑ Kidney Stones	❑ Loss of Memory	❑ Loss of Balance	❑ Loss of Smell	❑ Loss of Taste	❑ Neck Pain/Stiffness
❑ Nervousness	❑ Nosebleeds	❑ Pacemaker	❑ Polio	❑ Poor Posture	❑ Prostate Trouble
❑ Sciatica	❑ Short Breath	❑ Sinus Infection	❑ Sleep Disorder	❑ Spinal Curvature	❑ Stroke
❑ Swollen Ankles	❑ Swollen Joints	❑ Thyroid Condition	❑ Tuberculosis	❑ Ulcers	❑ Varicose Veins
❑ Venereal Disease	❑ Other ________				

Lifestyle and Habits

Job Description (desk job, physical lifting, on feet, etc.) ____________________

Work Schedule (Full-time, Part-time, Hours, Shift) ____________________

Recreational Activities (type and frequency) ____________________

Habits	None	Light	Moderate	Heavy
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Salty Foods	❑	❑	❑	❑
Sugary Foods	❑	❑	❑	❑
Artificial Sweetners	❑	❑	❑	❑

Question	Yes	No
Do You Experience Pain Everyday?	❑ Yes	❑ No
Do Symptoms Interfere with Life?	❑ Yes	❑ No
Does Pain Wake You at Night?	❑ Yes	❑ No
Symptoms Worse at Certain Times?	❑ Yes	❑ No
Does Weather Affect Your Symptoms?	❑ Yes	❑ No
Do You Wear Orthotics?	❑ Yes	❑ No
Do You Take Vitamin Supplements?	❑ Yes	❑ No
Do You Typically Sleep 7-8 Hours/Day	❑ Yes	❑ No

Average Level of Stress in Your Life

❑ No Stress ❑ Very Little Stress ❑ Some Occasional Stress ❑ Moderate Stress ❑ Significant Stess ❑ High Stress ❑ Severe Stress

Disclaimer:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this of fice of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to be paid directly to Dr. John R. Owings or Advanced Family Chiropractic Center P.C. However, in the event that the insurance company does not pay for services provided by the doctor, I understand that all billable services will be transferred to me, the patient, for payment and I am responsible for payment of those services. Insurance co-pays and deductibles are due at time of service.

Patient's Signature ____________________ Date ____________________

(If under 18, parent or guardian's signature)

Chiropractic Diagram

• Please print this page and then use a pen to complete the information requested below.

Name ______________________________ Sex ❑ F ❑ M Date _______/_______/_______

Using the Letters Below, Mark the Areas of the Diagram to Indicate Where You Feel the Following Sensations:

A = Aches **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing **O** = Other

Indicate the Severity of Your Symptoms by Marking an "X" within the Range Below:

How bad are your symptoms now?

no symptoms/pain — most severe symptoms/pain

How bad have they been in the past?

no symptoms/pain — most severe symptoms/pain

Name: ________________________________ Date: _______________ File#________

ADVANCED FAMILY CHIROPRACTIC

Privacy Practices Acknowledgement: HIPPA

As of April 2003, all health care providers are required by law to provide you the patient with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speak with any one of our staff.

Signature on file form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all insurance companies related to my care at Advanced Family Chiropractic.
- I authorize release of all medical / health information from any other provider I have used previously to Advanced Family Chiropractic and any agent working on their behalf.
- I authorize Advanced Family Chiropractic and any agent working on their behalf to obtain payment from my insurance company and / or attorney.
- I authorize payment to be made directly to Advanced Family Chiropractic.
- I permit a copy of this authorization to be used in place of the original.
- I permit Advanced Family Chiropractic and any agent working on their behalf to contact me by means of the home, work and / or cell phone number(s) I have provided on the patient information form.
- I permit Advanced Family Chiropractic and any agent working on their behalf to contact me via written communication to my home address given on the patient information form.

I have received the Notice of Privacy Practices and have reviewed it and I have reviewed the signature on file form.

Signature: ______________________________________ Date: ___________________

Name printed: ____