PATIENT APPLICATION FORM

Name: ______________________________ Age: ________ □ M/ □ F

Address: ______________________________ Birthday: __________

City: ______________ State: ________ Zip: ________ Email: ______________

Phone: Home ______________ Cell ______________ Work ______________

Marital Status: ____________ # of Children: ____________ Ages: ____________

Employer: ______________________ Type of work: ______________________

How were you referred to our office? ______________________________

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing this service strictly as a convenience for me. Advanced Spine will provide any necessary reports or required information to aid in insurance reimbursement for services. I understand that insurance carriers may deny my claims and that I am ultimately help responsible for any unpaid balance. Any monies received will be credited to my account.

Patient's Signature: ______________________________ Date: __________

Guardian/Spouse Signature Authorizing Care: ______________________ Date: __________

Name of Insurance Company: ______________________ Policy #: __________

Address: ______________________________ Phone #: __________

Insured Name: ______________________ Insured's SS #: __________

Relationship to the Insured: ______________________ Insured's Birthdate: __________

Employer: ______________________

Who should receive charges on your account?

□Patient □ Spouse □Parent/Guardian □Worker's Comp □Auto Insurance

□Medicare □Health Insurance

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Relationship: __________

Phone Number: ______________________ cell/home/work

PURPOSE OF THIS VISIT

Reason for this visit (Please describe) ______________________________

What Is this purpose related to? (Circle one) Auto Accident / Work Injury / Not related

When did this condition begin / when did you first notice it? ______________________________

Have you had this condition before? ☐ NO ☐ YES, if yes, when? ______________________________

What treatment have you tried? ______________________________

How did you respond? ______________________________

What activities aggravate your symptoms? ______________________________ Better? ______________

Who is your medical doctor or primary physician? ______________________________

Would you like us to share our findings with him / her? ☐ Yes ☐ No

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No

If yes, Who? ______________________________ When was the last time? ______________________________

Reason for your visits ______________________________

How did you respond? Got Better / No Change / Got Worse / Other ______________________________

Did you know your posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor postural habits? (Describe) ______________________________

HEALTH LIFESTYLE

On AVERAGE how much do you drink:

Water? __________ Soda? __________ Coffee? __________ Energy Drinks? __________

Juice? __________ Tea? __________ Alcohol? __________

How often do you exercise? ...What activates? ______________________________

You sleep on your... ☐ Stomach ☐ Side ☐ Back

How many hours of RESTFUL sleep per night? ______________________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? ______________________________

Do you smoke? ☐ Yes ☐ NO ☐ I don't anymore but, I used to.

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Doctor's Notes: ______________________________

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FAMILY HISTORY

Mother's side of family:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Grandmother:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Grandfather:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Aunts/Uncles:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Father's side of family:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Grandmother:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Grandfather:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Aunts/Uncles:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________
Brothers / Sisters:	□ Diabetes	□ Cancer	□ Heart Disease	□ Other ________

Please mark anything that you experience now or have in the past six (6) months.

NECK RELATED:

- □ Neck Pain/ Stiffness
- □ Headache/ Migraine
- □ Numb/ Tingling in Arms/ Hands
- □ Pain in Arms/ Hands
- □ Coldness in Hands
- □ Weakness in Grip
- □ Carpal Tunnel
- □ Fibromyalgia
- □ Low Energy/ Fatigue
- □ Hearing Disturbances
- □ Visual Disturbances
- □ Dizziness
- □ TMJ/ Jaw pain or Clicking
- □ Allergies/Hay Fever
- □ Sinusitis
- □ Recurrent Colds/ Flu
- □ Low Thyroid

MID BACK RELATED:

- □ Pain between Shoulder Blades
- □ Mid-Back Pain/ Stiffness
- □ Pain in Ribs/ Chest
- □ Tension in Shoulders
- □ Lung Infections/ Bronchitis
- □ Pain on Deep Breathing
- □ Tired or irritable after eating or if haven't eaten for a while.
- □ Heart Murmurs
- □ Diabetes
- □ Hypoglycemia
- □ Heart Attacks/ Angina
- □ Indigestion/ Heartburn
- □ Rapid Heart Beat
- □ Nausea
- □ Shortness of Breath
- □ Asthma/ Wheezing
- □ Reflux
- □ Heart Palpitations
- □ Ulcers/ Gastritis

LOW BACK RELATED:

- □ Low-Back Pain/ Stiffness
- □ Pain into your Hips/ Legs/ Feet
- □ Numbness/ Tingling in Legs/ Feet
- □ Coldness in Legs/ Feet
- □ Weakness in Legs/ Feet
- □ Menstrual Irregularities/ Cramping
- □ Injuries in Hips/ Knees/ Ankles
- □ Muscle Cramps in Legs/ Feet
- □ Bladder Infections
- □ Frequent/ difficulty urinating
- □ Sexual Dysfunction
- □ Constipation
- □ Diarrhea
- □ Irritable Bowel
- □ Osteoporosis

Please list any health conditions not mentioned above ________________________________

Please list medications/surgeries ________________________________

Please list any traumas (falls, car accidents, etc.) ________________________________