ADVANTAGE CHIROPRACTIC

Date: _____

New Patient Demographic Information

PATIENT INFORMATION

First Name:_____ Middle Initial:____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Birthdate:_____ Social Security #:_____ Sex (circle): M F

Email:_____ Occupation:_____

Phone Number (Home/Cell):_____

May we leave a message at: ☐ Home ☐ Cell

How did you hear about us? ☐ Google ☐ Family/Friend referral_____
Other: ☐ _____

Emergency Contact:_____ Phone:_____

OTHER INFORMATION

Have you seen a chiropractor before? ☐ Yes ☐ No
If so, name of office and location:_____

Have you had X-rays or other imaging taken recently? ☐ Yes ☐ No
If yes, date and location:_____

Is this visit related to a work/auto injury, slips, falls, etc. ☐ Yes ☐ No
_____

Have you ever been in a car accident? ☐ Yes ☐ No If so, when?_____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

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Patient or Guardian Signature:_____ Date:_____

REASON FOR TODAY'S VISIT

□ Emergency □ New Injury □ Old Injury □ Chronic Pain □ Wellness

Chief Complaint: _____

Rate the intensity of your symptoms at this moment: 0 1 2 3 4 5 6 7 8 9 10

When did the complaint occur? _____

Is your condition getting worse? □ Yes □ No □ Constant □ Comes and goes

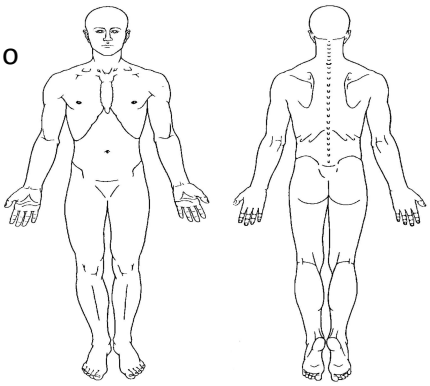
Is your condition interfering with? □ Work □ Sleep □ Daily routine

If so, how? _____

Has this happened in the past? □ Yes □ No

Explain: _____

USING THE ADJACENT CHART, PLEASE CIRCLE ALL AFFECTED AREAS



Have you been treated by another physician for this condition? □Yes □ No

If so, where? _____

Health History

Are you taking any of the following medications?

□ Pain Relievers (including aspirin) □ Muscle Relaxers □ Blood Thinners

□ Insulin □ Nerve Pills □ Tranquilizers

Other medications: _____

Do you have or have you had any of the following diseases, medical conditions, or procedures

Y N Alcoholism	Y N Difficulty Breathing	Y N High/Low Blood Pressure
Y N Anemia	Y N Drug Addiction	Y N HIV+/AIDS/ARC
Y N Arteriosclerosis	Y N Emphysema/COPD	Y N Kidney Problems
Y N Arthritis	Y N Epilepsy/Fainting/Seizures	Y N Low Back Problems
Y N Artificial Bones/Joints/Implants	Y N Fibromyalgia	Y N Migraines/Severe Headaches
Y N Artificial Valves	Y N Frequent Neck Pain	Y N Mitral Valve Prolapse
Y N Asthma	Y N Glaucoma	Y N Rheumatism/Rheumatic Fever
Y N Cancer	Y N Gout	Y N Shingles
Y N Chemotherapy	Y N Heart Attack/Stroke	Y N Sinus Problems
Y N Congenital Heart Defects	Y N Heart Murmurs	Y N Tuberculosis
Y N Depression/Psychosis	Y N Heart Surgery	Y N Ulcers/Colitis
Y N Diabetes	Y N Hepatitis	Y N Venereal Disease

Please list any surgeries with dates and/or any other serious medical conditions not listed above:_____

Please list any allergies: _____

Family Health History: _____

Do you take vitamins/supplements? □ Yes □ No **Do you exercise?** □ Yes □ No **Do you smoke?** □ Yes □ No

***FOR WOMEN:* Are you taking Birth Control?** □ Yes □ No **Are you Pregnant?** □ Yes □ No **Are you nursing** □ Yes □ No

I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and understand it's my responsibility to inform this office of any changes to the information I have provided

Patient OR Guardian Signature: _____ Date: _____