NEW PATIENT HEALTH HISTORY

ADVANCED
FAMILY CHIROPRACTIC CENTER

Two options for completing this form:

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

Note: Regardless of the completion method selected above, the diagrams on page four and signatures on pages three, five, and six require you to use a pen to complete them. If you email us the form, this can be done in our office.

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 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 offers convenient payment plans that fit most budgets.

Reasons for Seeking Care

Chief Complaint (include location) _____

Rate Intensity (0 = No Pain/Symptoms, 10 = W orst 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 = W orst 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 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.) _____

_____

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)

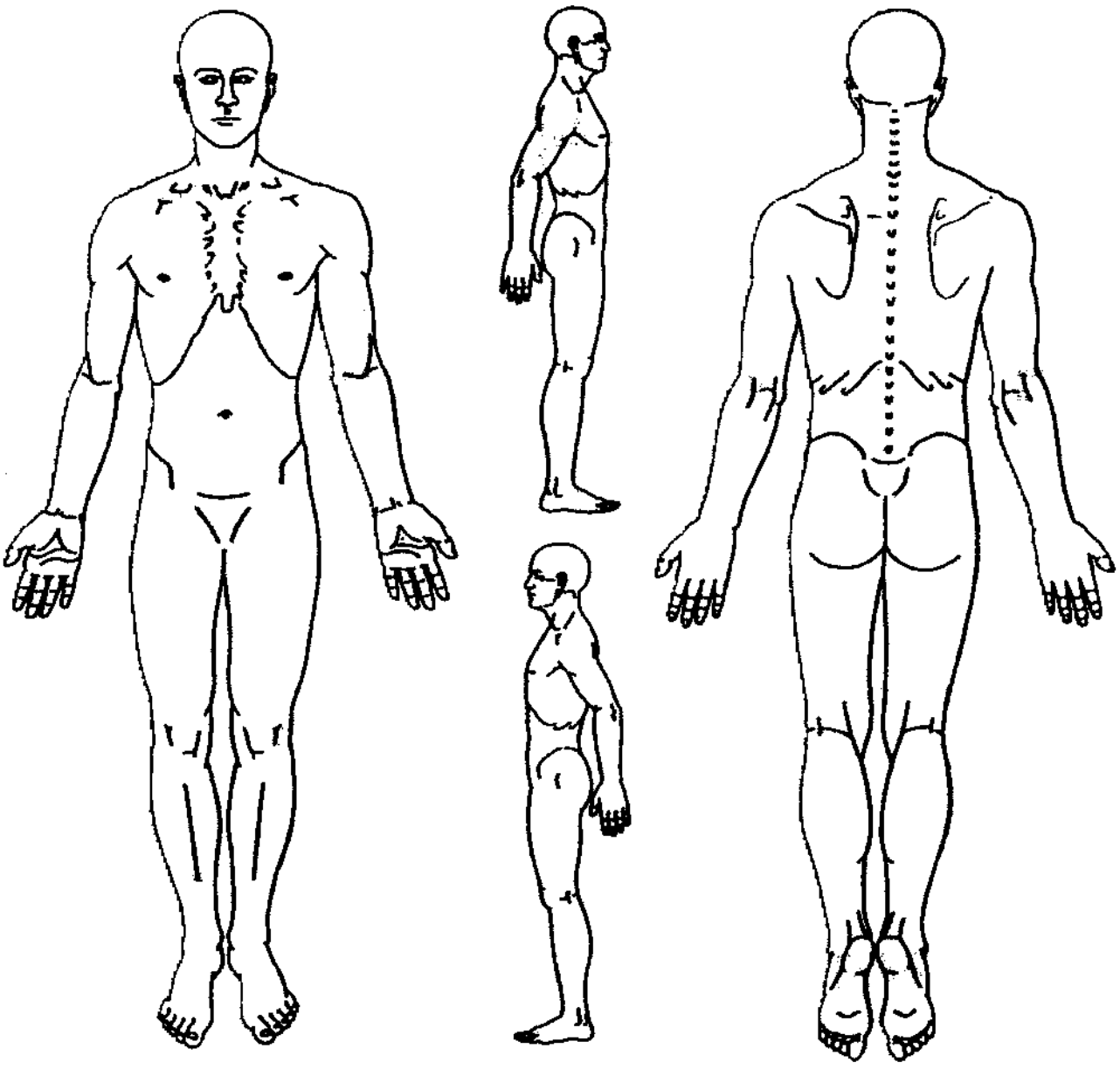
Chiropractic Diagram

• 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

Your Personal Health Goals

At Advanced Family Chiropractic Center, we are not only here to help you with your current health issues, but also want to assist you in any way we can by helping you achieve a much higher level of wellness. To help me serve you in the best way possible, please share your personal goals with me. Together, we will look at these goals and make this your healthiest year yet!

Name: _____ Date: _____/_____/_____

My current physical activities include:

❑ Basketball
❑ Baseball/Softball
❑ Bicycling
❑ Bowling
❑ Golf
❑ Tennis
❑ Weight Training
❑ Running
❑ Football
❑ Treadmill/Elliptical
❑ StairMaster
❑ Yoga/Pilates
❑ Dance
❑ Hockey
❑ Martial Arts
❑ Soccer
❑ Swimming/Water Aerobics
❑ Walking
❑ Other: _____

I would feel so much better if I could ...

❑ Decrease my stress
❑ Decrease my anxiety
❑ Sleep better
❑ Have more energy
❑ Handle my food and/or outdoor allergies
❑ Lose weight. I would love to lose _____ pounds!
❑ Eat healthier
❑ Help with sugar cravings
❑ Start a personalized diet, organic diet or gluten-free diet
❑ Lower my blood pressure
❑ Lower my cholesterol
❑ Lower my blood sugar
❑ Increase my flexibility
❑ Strengthen my core muscles
❑ Improve my posture
❑ Improve workstation ergonomics
❑ Quit smoking
❑ Eliminate caffeine
❑ Eliminate alcohol
❑ Decrease fatigue
❑ Have more time with family
❑ Have more time for myself
❑ Learn sport-specific exercises. Sport: _____
❑ Start a new sport/activity: _____

Women Only:

❑ Decrease PMS symptoms
❑ Get pregnant
❑ Balance my hormones
❑ Control menopausal symptoms
❑ Decrease PCOS symptoms
❑ Decrease endometriosis symptoms

Please brainstorm on any other health goals you have that I can assist you with:

_____

_____

Thank you for sharing your most personal goals. I look forward to watching your great progress!