Advantage CHIROPRACTIC

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip code: _____

Cell Phone: _____ Email: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other Number of Children: _____

Employer: _____ Position Title: _____

PAYMENT METHOD: ☐ Cash ☐ Check ☐ Credit Card ☐ HSA ☐ Other: _____

ABOUT YOUR SPOUSE

Spouse Name: _____ Phone: _____

Spouse Employer: _____ Position Title: _____

HEALTH HABITS

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week? _____

Do you drink ☐ coffee ☐ tea or ☐ soda? If yes, how much per week? _____

Do you exercise regularly? ☐ Yes ☐ No ☐ Sometimes

Do you wear: ☐ Heel lifts ☐ Sole Lifts ☐ Inner soles ☐ Arch supports ☐ None

CHIROPRACTIC EXPERIENCE

How did you hear about us? I was referred by: _____

☐ I live/work in area ☐ Social media ☐ Google ☐ Community event ☐ Other: _____

Have you been adjusted by a Chiropractor before? ☐ Yes ☐ No

If yes, approximate date of last adjustment? _____

Doctors name: _____ Reason for those visits? _____

REASON FOR THIS VISIT

Describe reason for this visit: _____

Is the purpose of this appointment related to:

☐ Work ☐ Sports ☐ Auto ☐ Fall ☐ Chronic discomfort ☐ Other: _____

When did this condition begin? _____

Has this condition: ☐ Gotten worse ☐ Stayed constant ☐ Come and gone

Has this condition occurred before: ☐ Yes ☐ No

Have you seen other doctors for this condition? ☐ Yes ☐ No

Type of treatment: _____

YOUR CONCERNS

Please circle the areas (spinal bone) or symptoms you are currently experiencing or have concerns about. Each area of concern relates to an area of the spine and nerve function.

Other concerns:

_____

_____

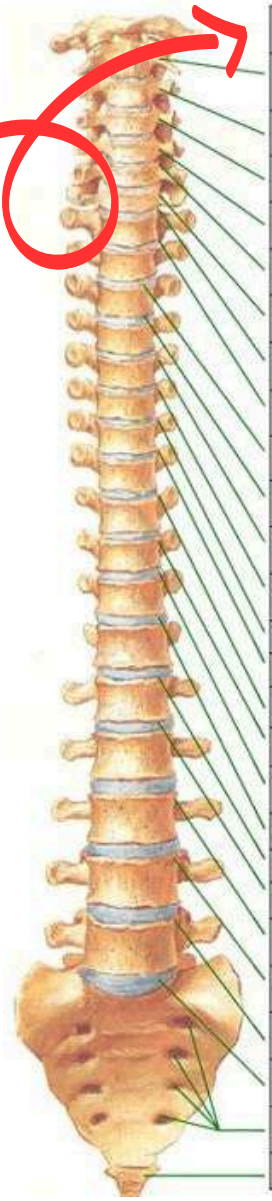
_____

_____

_____

_____

_____



Symptoms of Subluxation

Spinal Bone	Nerve Supply	Symptoms
C1	Blood Supply to the head, Pituitary Gland, Scalp, Bones of the face, Brain, Inner Ear and Middle Ear	Headaches-Insomnia-High Blood Pressure Migraines- Chronic Fatigue-Dizziness
C2	Eyes, Ears, Sinuses, Tongue, Forehead	Sinusitis-Earaches-Pain around the eyes Vision Problems-Hearing Problems
C3	Cheeks, Outer Ear, Face Bones, Teeth, Facial Nerves	Neuralgia-Pimples-Eczema
C4	Nose, Lips, Mouth, Eustachian tube	Hay Fever-Runny Nose-Hearing Loss Adenoids
C5	Vocal Cords, Neck, Glands, Pharynx,	Sore Throat-Laryngitis-Hoarseness
C6	Neck Muscles, Shoulders, Tonsils	Stiff Neck-Arm Pain-Tonsillitis Persistent Cough
C7	Thyroid Gland, Shoulder Bursa, Elbows	Bursitis-Colds-Thyroid Conditions
T1	Forearms, hands, Wrists, Fingers, Esophagus, Trachea	Arm and Hand Pain-Difficulty Breathing Shortness of Breath-Asthma
T2	Heart, Coronary Arteries	Heart Conditions-Chest Conditions
T3	Lungs, Bronchial tubes, Pleura, Chest	Bronchitis-Pleurisy-Pneumonia-Congestion
T4	Gallbladder	Gallbladder Conditions-Jaundice Shingles
T5	Liver, Solar Plexus, Circulation	Liver Conditions-Blood Pressure Conditions-Poor Circulation
T6	Stomach	Indigestion-Heartburn-Dyspepsia
T7	Pancreas, Duodenum	Ulcers-Gastritis
T8	Spleen	Lower Resistance
T9	Adrenal Glands	Allergies-Chronic Fatigue
T10	Kidneys	Kidney Problems-Hardening of the Arteries-Fatigue-Nephritis
T11	Kidneys, Ureters	Skin Conditions-Eczema-Pimples
T12	Small Intestines, Lymph Circulation	Rheumatism-Gas Pains
L1	Large Intestines, Inguinal rings	Colitis-Diarrhea-Hernia
L2	Appendix, Abdomen, Thigh	Cramps-Varicose Veins-Leg Pain
L3	Sex Organs, uterus, Bladder, Knees	Menstrual Pains-Irregular Periods-Miscarriages-Impotency-Knee Pain
L4	Prostate Gland, Lower Back	Back Pain-Difficulty, Painful or Frequent Urination
L5	Lower Back, Buttocks, Thighs, Legs, Feet, Sciatic Nerve, Large Intestine	Back Pain-Leg Pain-Constipation
Sacrum	Hip Bones, Buttocks	Sacroiliac Conditions-Back Pain-Hip Pain
Coccyx	Rectum, Anus	Hemorrhoids-Tail Bone Pain

HEALTH CONDITIONS

Have you been diagnosed with any diseases or conditions? ☐ **Yes** ☐ **No**

If yes, what diseases or conditions? _____

_____

Are you currently taking any medications? ☐ **Yes** ☐ **No**

If yes, what? _____

***Women Only:** **Are you pregnant?** ☐ **Yes** ☐ **No** **Are you nursing?** ☐ **Yes** ☐ **No**

GOALS FOR CARE

People see a chiropractor for a variety of reasons. Some go for relief of neck or back pain, headaches, sciatica, or stiffness, as well as to improve posture, mobility, and overall wellness. Chiropractic care offers a natural, drug-free approach that helps restore movement, reduce tension, and support long-term health so you can stay active and feel your best.

Please check the type of care desired so that we can best support your preferences

☐ **Relief Care:** Symptomatic relief of pain or discomfort

☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms

☐ **Integrated Wellness Care:** routine, preventive chiropractic treatment that helps maintain spinal function, support mobility, and reduce the risk of future issues.

☐ **I want the Doctor to select the type of care appropriate for me**

Advantage CHIROPRACTIC

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through examinations, adjustments, soft-tissue work, and therapeutic exercises, as he deems appropriate. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Print Patient Name: _____

Patient / Guardian Signature: _____ **Date:** _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have hereby read and understand your Notic of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient / Guardian Signature: _____ **Date:** _____

ELECTRONIC HEALTH RECORD INTAKE

Email: _____ @ _____

Preferred method of communication:

☐ **Email** ☐ **Text** ☐ **Phone Call** ☐ **Mail**

Preferred Language: _____

Smoking Status:

☐ **Everyday Smoker** ☐ **Occasional Smoker** ☐ **Former Smoker** ☐ **Never Smoker** ☐ **Vape**

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American
White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

FOR OFFICE USE ONLY

Height: _____ **Weight:** _____ **BP:** _____ / _____ **Pulse:** _____