# Patient Information & History

We are pleased to welcome you to Advanced Spinal Fitness. Please take a few minutes to complete your health profile as completely as you can. If you have questions, we'll be glad to help you. We look forward to helping you and your family achieve maximum health through Chiropractic.

Name _____ Soc. Sec. # ____-____-____
Last Name First Name Initial

Address _____ Sex: ❒ M F

City _____ State _____ Zip _____

Home Phone # (___) ____-_____ Work Phone # (___) ____-_____ E-mail _____

Birth Date _____ Age _____ Single Married/Domestic Partnership Widowed Separated Divorced

Number of Children (if any) _____ Hobbies/Interests/Sports _____

Name of your M.D./D.O. _____ City _____ Phone # (___) ____-_____

Person to contact in case of emergency _____ Phone # (___) ____-_____

Your Employer _____ Occupation _____

Spouse/Partner or Parent's Name _____ Spouse/Partner's Birth Date _____

Spouse/Partner's Soc. Sec. # _____-____-_____ Spouse/Partner's Employer _____

This account is paid by You & : Spouse/Partner/Parent ❒ Primary Ins. ❒ Worker's Comp. ❒ Auto Ins. ❒ Medicare ❒ Other

Insurance Company _____ Contract # _____

Whom may we thank for referring you to Advanced Spinal Fitness? _____

## Reason for Visit

Your reason for this visit: ❒ Specific Problem (s) ❒ Prevention ❒ Wellness / Maximize Health Potential

Please list your symptomatic complaints (if any): _____

_____

_____

Have you ever seen a Chiropractor? ❒ Yes ❒ No If yes, when, and describe your experience? _____

_____

**Please check all that apply in regards to your <u>Chief Complaint</u>:**

Is pain getting: ❒ Worse ❒ Better ❒ Same Comes and Goes

Is pain interfering with: ❒ Work Hobbies Sports ❒ Family Sitting Standing Walking Sleeping Concentrating

**Please complete the following sentences:**

I am here because _____

My goal(s) for care is(are) _____

## Health History & Health Habits

**Please list any drugs or supplements you are currently taking:**

_____

_____

**How many times have you taken Antibiotics in the last 5 years?** ❒ None ❒ 1-3 ❒ 4-6 ❒ 6-10

**Please circle any surgeries you have had:** ❒ Spinal Surgery ❒ Heart ❒ Hernia Gall Bladder ❒Cancer

Appendectomy Tonsillectomy Hysterectomy –Complete/Partial Joint Replacement ❒

Other _____

**Have you ever been hospitalized when not for a birth or a surgery?** _____

**Car Accidents:** How many?____ When? _____

**Work Injuries:** How many?____ When? _____

**Lifting Injuries:** How many?____ When?_____

The condition of your spine and nervous system is an accumulation of everything that has happened to you from birth until now. Multiple uncorrected stresses over a lifetime result in layers of damage to your spine, which in turn can damage your organs and other parts of your musculoskeletal system.

**Please circle all that apply:**

| **Childhood** | **Activities** | **Work** | **Sleep** |
|---|---|---|---|
| ❒ Difficult Birth | ❒ Exercise/Lift Weights | Sit for Living | ❒ Side |
| ❒ Forceps/Suction | ❒ Golf | ❒ Stand for Living | ❒ Stomach |
| ❒ C-Section | ❒ Tennis/Racquetball | ❒ Heavy Lifting | ❒ Back |
| ❒ Yanked by Arm | Jogging | ❒ Desk/Computer | ❒ 2 or more Pillows |
| ❒ Heavy Backpack | Martial Arts | ❒ Work Longer Than 8 Hours | Do you flip or roll your |
| ❒ Childhood Falls | Bowling | Stooping | mattress every 3 months? |
| ❒ Gymnastics | Contact Sports | ❒Bending/Twisting | ❒ Yes ❒ No |

**Have you ever had or do you currently have any of the following?**

| | | | |
|---|---|---|---|
| ❒ Heart Disease | ❒ Dizziness | ❒ Sinus Problems | Herniated Disc, where? _____ |
| ❒ High Blood Pressure | Arm Pain | ❒ Allergies ❒ | Numbness, where? _____ |
| ❒ Cancer | ❒ Wrist Pain | ❒ Kidney Problems | Tingling, where? _____ |
| ❒ Diabetes ❒ | Mid Back Pain | ❒ Ulcer/Colitis | Muscle Spasms, where? _____ |
| ❒ Stroke | ❒ Shoulder Pain | ❒ Gout | ❒ Screws/Rods/Plates, where? _____ |
| ❒ Lower Back Pain ❒ | Hip Pain | ❒ Hepatitis | Artificial Joints, where? _____ |
| ❒ Leg Pain | ❒ Constipation ❒ | Difficulty Breathing | Recurring Infections, where? _____ |
| ❒ Neck Pain/Stiffness ❒ | Indigestion | ❒ Asthma | Other _____ |
| ❒ Headaches | ❒ Menstrual Cramps | ❒ Emphysema/Bronchitis | _____ |

**Do you have a family history of**: ❒ Cancer ❒ Diabetes ❒ Heart Disease ❒ Stroke ❒ High Blood Pressure

**Women**: Are you pregnant? ❒ Yes ❒ No Are you nursing? ❒ Yes ❒ No # of Pregnancies ____ # of Deliveries _____

Currently Using Birth Control? Yes No If yes, what kind? _____ Date of Last Menstrual Period _____

Menopausal or Post-Menopausal? Yes No

**Do you consume / use / do the following:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Alcohol | ❒ | ❒ | **Y** | **N** | Regular Exercise | | **Y** | **N** ❒ | ❒ |
| Coffee | ❒ | ❒ | **Y** | **N** | Organic Food | ❒ | **Y** | **N**❒ | |
| Tobacco | ❒ | ❒ | **Y** | **N** | Vitamins/Supplements | ❒ | **Y** | **N** ❒ | |
| Recreational Drugs | | | **Y** | **N**❒ | Purified Water ❒ | ❒ | **Y** | **N** | |

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate through use of chiropractic manipulation throughout my spine and/or extremities. Any x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at this office. The patient also agrees that he or she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any **pre-existing medically diagnosed conditions**, nor for any medical diagnosis.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____