ADVANCED PHYSICAL MEDICINE

WELCOME

Physical Therapy • Chiropractic • Rehab

ABOUT YOU

Today's Date _____ File # _____

Patient Name _____
(Last) (First) (MI)

What you prefer to be called _____ ○ Male ○ Female

Birth date _____ Age ____ SS# _____

Mailing Address _____

_____

Home Phone _____

Work Phone _____

Mobile Phone _____

Email Address _____

Referred By _____

Employer _____ How Long? _____

Employer Address _____

_____

Occupation _____

Status ○ Minor ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse's Name _____

Do you have children? ○ Yes ○ No How Many? _____

INSURANCE INFORMATION

Provider Name _____

Address _____

_____

Phone _____

Insured's SS# _____

Group Number _____

Insured's Name _____

Relation Date of Birth _____

Insured's Employer _____

*Please inform the front desk of a second insurance source

REASON FOR VISIT

Reason for this visit ○ Work ○ Sports ○ Auto ○ Trauma ○ Chronic

What happened _____

_____

Describe the pain and its location _____

_____

When did the condition begin? _____

Is this condition getting worse? ○ Yes ○ No ○ Constant ○ Comes and goes

Condition interferes with ○ Work ○ Sleep ○ Daily Routine

If so, explain _____

Have you had similar conditions in the past? ○ Yes ○ No

If so, explain _____

Have you been treated by a Medical Physician for this condition? ○ Yes ○ No

If so, where _____

Have you ever been treated by a chiropractor before? ○ Yes ○ No

If so, whom _____ Phone _____

CONTINUE ON BACK

HEALTH HISTORY

Are you taking any of the following medications?

○ Nerve pills ○ Pain killers (including aspirin) ○ Muscle relaxers ○ Stimulants
○ Blood thinners ○ Tranquilizers ○ Insulin ○ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

○ Heart Attack/Stroke	○ Heart Surg./Pacemaker	○ Heart Murmur
○ Congenital Heart Disease	○ Mitral Valve Prolapse	○ Artificial Valves
○ Alcohol/Drug Abuse	○ Venereal Disease	○ Hepatitis
○ HIV+/Aids	○ Shingles	○ Cancer
○ Frequent Neck Pain	○ Emphysema/Glaucoma	○ Anemia
○ High/Low Blood Pressure	○ Psychiatric Problems	○ Rheumatic Fever
○ Severe/Frequent Headaches	○ Kidney Problems	○ Ulcers/Colitis
○ Fainting/Seizures/Epilepsy	○ Sinus Problems	○ Asthma
○ Diabetes/Tuberculosis	○ Difficulty Breathing	○ Chemotherapy
○ Lower Back Problems	○ Artificial Bones/Joints	○ Arthritis

List any other serious medical condition(s) you have or ever had

_____

List anything you may be allergic to _____

_____

List previous surgeries/treatments with dates _____

_____

List any past serious accidents with dates _____

_____

Family Health History _____

_____

Do you take supplements or vitamins ○ Yes ○ No Exercise? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No Since _____

Do you smoke? ○ Yes ○ No How much? _____ How Long? _____

Are you wearing? ○ Heel lifts ○ Sole lifts ○ Inner soles ○ Arch supports

How old is your mattress? _____ Is it comfortable ○ Yes ○ No

For Women: Are you taking Birth Control ○ Yes ○ No

Are you Pregnant? Yes No How long? ____ Nursing ○ Yes ○ No

IN EVENT OF EMERGENCY

Provider Name _____

Relation _____

Home Phone _____

Work Phone _____

Your Medical Doctor _____

Phone _____

ACCOUNT INFORMATION

Person ultimately responsible for account

Name _____

Relation _____

Billing Address _____

_____

SS# _____

Drivers License # _____

Work Phone _____

Payment Method ○ Cash ○ Check ○ Credit

Card # _____ Expiration _____

_____ (Initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____ ○ Adult Patient ○ Parent or Guardian ○ Spouse