ADVANCED INTEGRATED HEALTHCARE LLC
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advancemyhealth.com
An Integrated Approach to Wellness

NEW PATIENT FORM

PERSONAL INFORMATION

Name:	Sex: M F	Date of Birth:	Date:
Address:	City:		State/Zip:
Home Phone:	Work Phone:	Cell Phone:	
Email:	Age:	Height:	Weight:
Occupation:	Employer:	Marital Status: S M D W	
Social Security Number:	Insurance Co.:	Number of Children:	

Who referred you to our office? _____

Please provide an emergency contact and phone number. _____

Is today's visit related to an auto or work related accident? Yes No If yes, when:_____

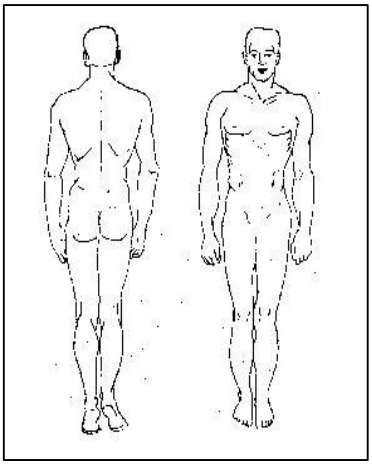
CASE HISTORY

Have you received chiropractic care before? Yes No

If yes, what for and when was the last visit? _____

Complaint #1	**Started on**	**How did it begin?**
What makes the condition better? What makes the condition worse?		
Complaint #2	**Started on**	**How did it begin?**
What makes the condition better? What makes the condition worse?		
Complaint #3	**Started on**	**How did it begin?**
What makes the condition better? What makes the condition worse?		
Complaint #4	**Started on**	**How did it begin?**
What makes the condition better? What makes the condition worse?		

Please circle the areas that bother you.



Which type of symptom do you experience? Dull Ache Sharp Shooting Burning Throbbing
Deep Stinging Numb Tingle Pins & Needles

Does the condition radiate to another part of your body? Yes No If yes, where?_____

Severity of Symptoms:	None					Moderate					Excruciating
On Average	0	1	2	3	4	5	6	7	8	9	10
At Best	0	1	2	3	4	5	6	7	8	9	10
At Worst	0	1	2	3	4	5	6	7	8	9	10

Symptoms are: occasional intermittent frequent constant
How long do they last? _____
When are your symptoms the worst? morning midday late afternoon evening all day
Other treatments for this condition: _____
Have you had any past injuries, fractures, surgeries, or illnesses that may have contributed to your condition? Yes No If yes, describe:_____
Other surgeries and dates:_____
Are you left or right dominant? Left Right Are you pregnant? Yes No

Please circle any conditions that you commonly experience or have had in the last 6 months.

Headaches	Sleeping problems	Back pain	Neck pain	Leg pain	Balance issues
Cholesterol	Asthma	Fatigue	Depression	Diarrhea	Upset stomach
Memory Loss	High Blood Pressure	Chest pain	Sciatica	Ears Ringing	Frequent Colds
Numbness	Cold hands/feet	Joint pain	Arthritis	Allergies	Arm/hand pain
Eating disorder	Menstrual cramps	Heart issues	Weight Loss	Dizziness	Painful urination
Sinus trouble	Irritable colon	Osteoporosis	Fainting	Constipation	Thyroid disorder

What does your condition prevent you from doing? _____
Medications and reasons for taking:_____
Vitamins/supplements taking regularly:_____
Rate your diet: Poor Fair Good Excellent
Exercise frequency per week: none 1-2x 3-4x 4-5x 6-7x
Describe regular exercise/activities you do._____
Allergies:_____ Smoking habits: Yes No If yes, how much?_____

PAST HEALTH HISTORY & FAMILY HISTORY

Write "**P**" for patient and "**F**" for family member that is blood relative

____	Abdominal pain	____	Diabetes	____	Gallstones	____	Multiple Sclerosis
____	Allergies	____	Disc Conditions	____	Heart Attack	____	Osteoporosis
____	Anorexia	____	Dislocations	____	High Blood Pressure	____	Prostate Disease
____	Arthritis	____	Dizziness	____	High Cholesterol	____	Scoliosis
____	Asthma	____	Emphysema	____	Irritable Bowel	____	Sickle Cell Anemia
____	Blood Disorders	____	Epilepsy	____	Kidney Disease	____	Stroke
____	Breast Condition	____	Fainting	____	Liver Disease	____	Thyroid Disorder
____	Bulimia	____	Fractures	____	Low Blood Pressure	____	Tuberculosis
____	Cancer	____	Frequent Urination	____	Lung Disease	____	Ulcer
____	Convulsions						

I have read the above information and certify it to be true and accurate to the best of my knowledge. I hereby authorize the Doctor to provide me with evaluation and treatment of my condition in accordance with Georgia's statutes.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____