Advanced Chiropractic
Of South Carolina

Date_____ Patient #_____

Patient Information

Name_____ Address_____

City_____ State_____ Zip/Postal Code_____

Home Phone_____ Birth Date_____ Age_____ Sex [ ] M [ ] F

Social Security #_____ Circle One: Married Single Widowed Divorced Separated

Business Employer_____ Type of Work_____

E-Mail Address_____ Referred To This Office By_____

Business Phone_____ Mobile Phone_____

Name Of Spouse_____ Spouse's Social Security #_____

Spouse's Employer_____ Business Phone_____

Type of Work_____ Name and Ages of Children_____

Name and Number of Emergency Contact_____ Relationship_____

Who is Responsible For Your Bill, You and [ ] Spouse [ ] Workers' Comp [ ] Auto Insurance

Health Insurance Company Name_____

Claims Address_____ Phone#_____

Name of Insured_____ Insured Date of Birth_____

Relationship to Insured_____ Policy #_____ Group #_____

Any Other Insurance Coverage Information_____

Current Health Condition

Purpose of This Appointment_____

Other Doctors Seen For This Condition [ ] Yes [ ] No Who?_____

Type of Treatment_____ Results_____

When Did This Condition Begin?_____ Has This Condition Occurred Before? [ ] Yes [ ] No

List Any Medication You Are Currently Taking_____

_____

Is Patient Pregnant? [ ] Yes [ ] No Do You Take Vitamins? [ ] Yes [ ] No Do You Wear Shoe Lifts? [ ]Yes [ ]No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?_____

List all major accidents or falls:_____

_____

_____

_____

_____

Patient Health History

Please check and Describe:
Major Surgery/Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gall Bladder [ ] Hernia [ ] Back Surgery [ ] Broken Bones

Other:_____

Hospitalization (Other than Above)_____

Date of last chiropractic visit: _____ [ ] None Doctor's Name_____

Please Check All the Following That Apply:

[ ]Allergies/Hay Fever	[ ]Poor Posture	[ ]Pacemaker	[ ]Blood clots	[ ]Detached Retina
[ ]Sciatica	[ ]Bruise Easily	[ ]Tuberculosis	[ ]Itching	[ ]Dizziness
[ ]Swollen Joints	[ ]Bed Wetting	[ ]Vericose Veins	[ ]Fatigue	[ ]Nosebleeds
[ ]Loss of Sleep	[ ]Diarrhea/Constipation	[ ]Headache	[ ]Colon Trouble	[ ]Frequent Urination
[ ]Indigestion	[ ]High Blood Pressure	[ ]Sinus	[ ]Kidney Stone/Infection	[ ]Ulcers
[ ]Heartburn	[ ]Pain Over Heart	[ ]Low Blood Pressure	[ ]Prostate Trouble	[ ]Numbness
[ ]Bursitis	[ ]Asthma	[ ]Nervousness/Depression	[ ]Cramps or Backache	[ ]Arthritis
[ ]Hemorrhoids	[ ]Colds	[ ]Rapid Heartbeat	[ ]Poor Circulation	[ ]Arrythmias
[ ]Nausea	[ ]Deafness	[ ]Slow Heartbeat	[ ]Stroke	[ ]Hot Flashes
[ ]Foot Trouble	[ ]Ear Noises	[ ]Chest Pain	[ ]Difficult Breathing	[ ]Irregular Cycle
[ ]Low Back Pain	[ ]Ears Stopped Up	[ ]Pleurisy	[ ]Swelling of Ankles	[ ]Lumps in Breast
[ ]Thrombophlebitis	[ ]Eye Pain	[ ]Cancer	[ ]Diabetes	[ ]Venereal Disease
[ ]Neck Pain/Stiffness	[ ]Acute Phlebitis	[ ]Polio	[ ]Failing Vision	[ ]Enlarged Thyroid
[ ]Excessive Menstrual Flow		[ ]Allergy to Cold	[ ]Raynaud's Phenomenon	

Tingling or Stiffness In: [ ]Shoulders [ ]Hips [ ]Arms [ ]Legs [ ]Elbows [ ]Knees [ ]Hands [ ]Feet

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Patient Habits

Do You Exercise Regularly? [ ] Yes [ ] No Do You Use An Orthopedic or Cervical Pillow? [ ] Yes [ ] No

Are You Wearing? (Please Check All That Apply) Heel Lifts____ Sole Lifts____ Inner Soles____ Arch Supports____

Please Check All That Apply:

	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Assignments of Benefits

I acknowledge that I am wholly responsible for any difference in a payment between the insurance benefits and the total health care bill. For the services rendered, I hereby assign all my medical benefits available for the services to the undersigned doctor of chiropractic, and I also authorize the information necessary to process this claim to be released to the company processing the claim. Photocopies of this assignment are considered to be true and correct as the original agreement drafted by both doctor and patient.

Signature of Patient_____ Date_____

Responsible for Bill_____ Date_____

Patient's Permission to Treat_____ Date_____

Permission to Treat Child_____ Date_____

ALL X-RAYS TAKEN ARE FOR IN-OFFICE USE ONLY. If this is an auto accident case and patient's insurance company or attorney does not settle this case within one year of the accident date the patient will be responsible for any and ALL charges that have accrued.

COMPLAINT:

Major **Secondary** **Tertiary** **Other**

_____ **Patient Name**

_____ Please mark area of this complaint on figures below

_____

Date when symptom first appeared_____

Is the result of an accident? O No O Yes Date:_____

If Yes, OWork OAuto Accident OHome

OOther:_____

_____

Has a Report been filed? OYes ONo

How often do you experience the symptoms?

OConstant (100% of time) OFrequent (75% of time)

OIntermittent (50% of time) OOccasional (25%) ORare (10%)

How many days of the month do you feel it (out of 30)?____

How many hours of the day do you feel it (out of 24)?_____

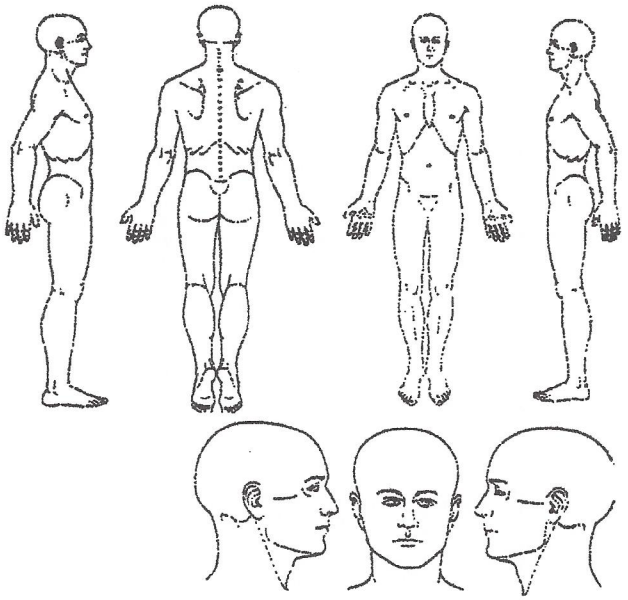
When? OMorning OAfternoon OEvening ONight

What increases symptom?_____

_____

What relieves symptom?_____

_____



Type of Pain:

OSharp ODull OAching OBurning

OThrob ONumb OOther_____

Does it radiate? ONo OYes Where?_____

Rate how it is now (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

Rate how it is on average (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

Rate how it is at it's worse (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

Rate how it is at it's best (0 is no pain/symptom, 10 unbearable. Circle one.): **0 1 2 3 4 5 6 7 8 9 10**

How does this symptom affect your:

Work?_____

_____

Home life?_____

_____

Leisure activities?_____

_____

Sleep?_____

_____

O Additional notes on back of sheet.

_____ _____

Patient Signature Date