

NEW PATIENT HEALTH HISTORY

Two options for completing this form:

- Please fill out on your computer, print it, and bring it to your first appointment.
- Please print out this form, then fill it out using a pen, and bring it to your first appointment.

Note: Regardless of the completion method selected above, the diagrams on page four and signatures on pages three, five, and six require you to use a pen to complete them. If you email us the form, this can be done in our office.

Patient Contact Information

Patient's Full Name _____ Sex F M Date ____/____/____

Patient's Social Security # _____ Date of Birth ____/____/____ Age _____

E-mail _____

Parent or Guardian's Name (if patient under age 18) _____

Address _____ Apt. (if applicable) _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Emergency Contact _____ Emergency Contact Phone (_____) _____

Patient's Occupation _____ Employer _____

Patient's Marital Status Single Married Divorced Widowed If Married, Spouse's Name _____

Number of Children _____ Spouse's Occupation _____ Spouse's Employer _____

Name of Referring Physician, Patient, or Family Member (if applicable) _____

Insurance Coverage Information

Do You Have Health Insurance Coverage? Yes No* If yes, please present your health insurance ID card when you arrive at our office for your first visit. We will make a photocopy of it for our files.

If insured, are you the primary name on the policy or is your spouse? I am the primary name My spouse is the primary name

If Spouse, Spouse's Name _____ DOB ____/____/____

Are You Enrolled in Medicare Medicaid? If you have Medicare supplemental insurance, please present your health insurance ID card when you arrive at the our of fice for your first visit. We will make a photocopy of it for our files.

Are you suffering from an auto accident injury that resulted in a claim? Yes No If yes, please bring the auto accident claim information received from your insurance agent. We will make a photocopy of it for our files.

* If you do not have health insurance coverage, Advanced Family Chiropractic Center offers convenient payment plans that fit most budgets.

Reasons for Seeking Care

Chief Complaint (include location) _____

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms) 0 1 2 3 4 5 6 7 8 9 10

Secondary Complaint, if any (include location) _____

Rate Intensity (0 = No Pain/Symptoms, 10 = Worst Possible Pain/Symptoms) 0 1 2 3 4 5 6 7 8 9 10

Have You Ever Received Chiropractic Care? Yes No If Yes, When? _____

Nature of Injury Automobile Work Other _____

Complaint(s) Began When & How? _____

Reasons for Seeking Care (continued)

Description of the Complaint/Pain: Dull Aching Sharp Shooting Burning Throbbing Deep Nagging
 Other Describe _____

Does This Pain Radiate or Travel (Shoot) to Any Other Areas of Your Body? Yes No If Yes, Where? _____

Do You Have Any Numbness or Tingling in Your Body? Yes No If Yes, Where? _____

How Frequent Is Complaint Present, How Long Does It Last? _____

Does Anything Aggravate the Pain? _____

Does Anything Make the Pain Better? _____

Medical History

Your Height: _____ feet _____ inches Your Weight: _____ pounds

Previous Care for Your Complaint/Pain (Treatments, Medications, or Surgery You've Sought for Your Complaint) _____

Have You Been Treated for Any Conditions in the Last Year? Yes No If Yes, What? _____

Approximate Date of Last Physical Exam _____ / _____ / _____ Females: Could You Be Pregnant? Yes No Not Sure

Have You Had X-Rays Taken in the Past Three Years? Yes No If Yes, Where? _____

What Medications Are You Taking and for What Conditions (Please List Dosage and Amounts, etc.) _____

What Vitamins, Minerals, or Herbs Do You Currently Take? (Please List Dosage and Amounts, and for What Condition, etc.) _____

Family Member (Mother, Father, etc.) Present and Past Health Conditions (Heart Disease, Cancer, Diabetes, Arthritis, etc.)

1. _____

2. _____

3. _____

Have You Ever:

If Yes, Briefly Explain:

Broken Bones Yes No _____

Been Hospitalized Yes No _____

Been in an Auto Accident Yes No _____

Had Sprains/Strains Yes No _____

Had a Sports Injury Yes No _____

Been Struck Unconscious Yes No _____

Had Surgery Yes No _____

Used a Cane or Walker Yes No _____

Medical History (continued)

Have You Ever Suffered from:

- | | | | | | |
|---|--|--|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Extremities | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cramps | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Eye Pain/Problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Irregular Cycles | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Neck Pain/Stiffness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Polio | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Prostate Trouble |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Short Breath | <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Other _____ | | | | |

Lifestyle and Habits

Job Description (desk job, physical lifting, on feet, etc.) _____

Work Schedule (Full-time, Part-time, Hours, Shift) _____

Recreational Activities (type and frequency) _____

Habits	None	Light	Moderate	Heavy	Do You Experience Pain Everyday?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do Symptoms Interfere with Life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does Pain Wake You at Night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Symptoms Worse at Certain Times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does Weather Affect Your Symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do You Wear Orthotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do You Take Vitamin Supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do You Typically Sleep 7-8 Hours/Day	<input type="checkbox"/> Yes <input type="checkbox"/> No
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Average Level of Stress in Your Life

- No Stress Very Little Stress Some Occasional Stress Moderate Stress Significant Stress High Stress Severe Stress

Disclaimer:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

I authorize the release of any medical information necessary to process this claim and request payment of insurance benefits to be paid directly to Dr. John R. Owings or Advanced Family Chiropractic Center P.C. However, in the event that the insurance company does not pay for services provided by the doctor, I understand that all billable services will be transferred to me, the patient, for payment and I am responsible for payment of those services. Insurance co-pays and deductibles are due at time of service.

Patient's Signature _____ Date _____

(If under 18, parent or guardian's signature)

Your Personal Health Goals

At Advanced Family Chiropractic Center, we are not only here to help you with your current health issues, but also want to assist you in any way we can by helping you achieve a much higher level of wellness. To help me serve you in the best way possible, please share your personal goals with me. Together, we will look at these goals and make this your healthiest year yet!

Name: _____

Date: ____/____/____

My current physical activities include:

- | | | |
|--|---|--|
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Weight Training | <input type="checkbox"/> Dance |
| <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Running | <input type="checkbox"/> Hockey |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Football | <input type="checkbox"/> Martial Arts |
| <input type="checkbox"/> Bowling | <input type="checkbox"/> Treadmill/Elliptical | <input type="checkbox"/> Soccer |
| <input type="checkbox"/> Golf | <input type="checkbox"/> StairMaster | <input type="checkbox"/> Swimming/Water Aerobics |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Yoga/Pilates | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Other: _____ | | |

I would feel so much better if I could ...

- | | |
|--|---|
| <input type="checkbox"/> Decrease my stress | <input type="checkbox"/> Increase my flexibility |
| <input type="checkbox"/> Decrease my anxiety | <input type="checkbox"/> Strengthen my core muscles |
| <input type="checkbox"/> Sleep better | <input type="checkbox"/> Improve my posture |
| <input type="checkbox"/> Have more energy | <input type="checkbox"/> Improve workstation ergonomics |
| <input type="checkbox"/> Handle my food and/or outdoor allergies | <input type="checkbox"/> Quit smoking |
| <input type="checkbox"/> Lose weight. I would love to lose _____ pounds! | <input type="checkbox"/> Eliminate caffeine |
| <input type="checkbox"/> Eat healthier | <input type="checkbox"/> Eliminate alcohol |
| <input type="checkbox"/> Help with sugar cravings | <input type="checkbox"/> Decrease fatigue |
| <input type="checkbox"/> Start a personalized diet, organic diet or gluten-free diet | <input type="checkbox"/> Have more time with family |
| <input type="checkbox"/> Lower my blood pressure | <input type="checkbox"/> Have more time for myself |
| <input type="checkbox"/> Lower my cholesterol | |
| <input type="checkbox"/> Lower my blood sugar | |
| <input type="checkbox"/> Learn sport-specific exercises. Sport: _____ | |
| <input type="checkbox"/> Start a new sport/activity: _____ | |

Women Only:

- | | |
|--|--|
| <input type="checkbox"/> Decrease PMS symptoms | <input type="checkbox"/> Decrease PCOS symptoms |
| <input type="checkbox"/> Get pregnant | <input type="checkbox"/> Decrease endometriosis symptoms |
| <input type="checkbox"/> Balance my hormones | |
| <input type="checkbox"/> Control menopausal symptoms | |

Please brainstorm on any other health goals you have that I can assist you with:

Thank you for sharing your most personal goals. I look forward to watching your great progress!

Name: _____ Date: _____ File# _____

ADVANCED FAMILY CHIROPRACTIC Privacy Practices Acknowledgement: HIPAA

As of April 2003, all health care providers are required by law to provide you the patient with a Notice of Privacy Practices. The privacy of your protected health information (PHI) is important to us. We understand that your health information is personal and we are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. You are being provided a Notice of Privacy Practices which explains how we may use and share PHI about you. If, at any time, you have questions or concerns related to your protected health information, please feel free to speak with any one of our staff.

Signature on file form

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all insurance companies related to my care at Advanced Family Chiropractic.
- I authorize release of all medical / health information from any other provider I have used previously to Advanced Family Chiropractic and any agent working on their behalf.
- I authorize Advanced Family Chiropractic and any agent working on their behalf to obtain payment from my insurance company and / or attorney.
- I authorize payment to be made directly to Advanced Family Chiropractic.
- I permit a copy of this authorization to be used in place of the original.
- I permit Advanced Family Chiropractic and any agent working on their behalf to contact me by means of the home, work and / or cell phone number(s) I have provided on the patient information form.
- I permit Advanced Family Chiropractic and any agent working on their behalf to contact me via written communication to my home address given on the patient information form.

I have received the Notice of Privacy Practices and have reviewed it and I have reviewed the signature on file form.

Signature: _____ Date: _____

Name printed: _____

Dear Patient:

We are happy to have you as a part of our practice. Our general rule for payment is that payment is due when services are rendered.

This means that you are responsible for payment to us, even if you have insurance which may cover some of our entire bill.

This agreement applies to both goods and services provided by our office.

We must run our office as a business, in order to be fair to our staff and other patients. This letter explains our policies about payment. We ask that you agree to these policies as a patient of our office.

If we extend credit to you by permitting you to defer payment until your insurance company considers the claim or for some other reason, these are the terms and conditions that apply:

1. You are responsible for payment.
2. If you have insurance and our office participates with your insurance, we will comply with all contractual requirements. You are still responsible for all contractual payments to our office, such as co-pays and deductibles.
3. We will file electronic forms in accordance with the standard practices of the industry to assist in obtaining payment.
4. We reserve the right to charge to fill out forms or provide medical correspondence beyond the usual and necessary submissions to your insurance carrier.
5. We will not charge interest on the bill until at least 90 days have gone by since the date of service.
6. We ask that you agree to keep us up to date with your current address and phone number.
7. If you ever have a question about a bill from our office, we ask that you let us know within 30 days of receiving the bill. If you do not do so, we will assume the bill is correct.
8. We may charge interest after 90 days. Our interest rate is seven percent (7%) simple interest per annum, or the maximum permitted by Michigan law, whichever is the lessor.
9. We promise to mail a copy of the bill by first class mail to your last known address on file before we turn over your account to our attorney to collect your bill.
10. If we do not receive payment, and we need to send your account to our attorney for collection of the bill, we ask that you agree by signing this letter to pay the cost of the collection, including court fees and actual attorney fees.
11. If you are having trouble paying your bill, you should immediately talk to the doctor. We try to work with our patients, to make sure that they can afford our services.

I agree to these terms and conditions regarding payment for services rendered to me as a patient. If I am the parent of a minor child, I agree to be responsible for payment and agree to these terms on behalf of my child.

Date: _____

Signature: _____