[1]So we can better serve you, please fill in ALL requested information.

Today's date _____

Last Name _____ First Name _____ MI ____ M/F Date of Birth _____

Address _____ City _____ State _____ Zip_____

Email address _____ Drivers License # _____ Social Security #_____

Telephone: Cell _____ Home _____ Work _____

What is the best way to contact you? (circle one or more) Cell Phone Home Phone Work Phone Email

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Marital Status: Married/ Divorced/ Widow/ Single (circle)
Spouses Name:_____ Occupation/Company_____

Emergency Contact _____ Phone # _____ Relation _____

How did you hear about us_____

Have you ever been to a chiropractor for this or any other condition? Yes/No _____

If yes, who? _____ Address _____ City_____ State ____ Zip _____

For what condition? _____ How was your experience? _____

What condition prompted you to call/visit our office today? _____

Who is your primary care physician/family doctor including address and phone?_____

Email:_____

Do you have health insurance? Y or N Do you carry more then one insurance policy? Y or N

Insurance Carrier Name:_____Verification Phone Number:_____

Insurance Carrier Address:_____City _____State ____ Zip _____

If this insurance is held by another person, such as a spouse, what is their name?_____

Insured's address:_____ Insured Date of Birth?_____

Patient ID#_____Group #_____Other details_____

Secondary Coverage details:_____

_____

We will contact your health insurance company to verify eligibility. We will determine the following: Available benefits, deductible, co-payment amount or percentage, specific payable codes, eligibility for treatment, evaluation, imaging, orthotics, physiotherapy and any necessary pre-authorizations or referrals.

Please circle any that apply – specifics to be answered on the next page:

___ Neck Pain	___ Mid Back Pain	___ Low Back Pain	___ Pain when sneezing/coughing
___ Neck Stiffness	___ Shoulder Pain	___ Radiating Pain into buttock	___ Bowel/Bladder problems
___ Headaches	___ Arm pain/radiating	___ Radiating Pain into legs	___ Hip Pain
___ Sinus Issues	___ Hand/Arm tingling	___ Radiating in Both legs	___ Knee/Leg Pain/Problems

[1]

___ Allergies ___ Pain in Traps ___ Muscle Weakness ___ Ankle/Foot Pain/Problems

CURRENT SYMPTOMS – please fill in the information as thoroughly as possible – leave no blanks

What is *chief complaint*/location of **1ST PAIN**:_____

How long have you had this symptom/pain?_____Have you had this problem before? Y or N

If yes, how was it treated and what were the results?_____

DESCRIBE the pain (circle all that apply) dull sharp aching cutting throbbing burning numbing/numbness tingling cramping spasm stinging shooting pounding constricting

Other:_____

Pain **FREQUENCY** (awake time) up to ¼ of the time ¼- ½ the time ½ to ¾ of the time **most** of the time/constant

Pain **INTENSITY** Choose/circle one of the following:

1. The pain is annoying but does not interfere w/activities &/or sleep though no narcotic medication is necessary
2. The pain is tolerated but interferes w/activities &/or sleep -some meds including narcotic meds may be necessary
3. Moderate pain – severely limits activities (recreation & socialization are severely limited) &/or prevents sleep. The use of narcotic meds may be necessary.
4. The pain is marked and prevents activities and/or sleep with narcotic meds required which may not completely control the pain

Does the pain **RADIATE** into the head, neck, shoulder, arm, hand, hip, leg, foot or other:_____

If so, please indicate Right or Left side where applicable:_____

In the AM_____	Twisting left_____	Straining_____	Sitting _____
In the PM_____	Twisting right_____	Standing_____	Lifting _____
Bending forward_____	Bending left_____	Coughing_____	Walking_____
Bending backward_____	Bending right_____	Sneezing_____	Running_____

What is the **SEVERITY** of pain on a scale of 1(mild) to 10(severe or intolerable) 1 2 3 4 5 6 7 8 9 10

Location of **2ND PAIN/SYMPTOM**:_____

How long have you had this symptom/pain?_____Have you had this problem before? Y or N

If yes, how was it treated and what were the results:_____

DESCRIBE the pain (circle all that apply) dull sharp aching cutting throbbing burning constricting numbing/numbness tingling cramping spasm stinging shooting pounding Other:_____

Pain **FREQUENCY** (awake time) up to ¼ of the time ¼- ½ the time ½ to ¾ of the time **most** of the time/constant

Pain **INTENSITY** (circle/see details above) 1.does not affect 2. somewhat affects 3. seriously affects 4. prevents

Does the pain **RADIATE** into the head, neck, shoulder, arm, hand, hip, leg, foot or other:_____

If so, please indicate Right or Left side where applicable:_____

In the AM_____	Twisting left_____	Straining_____	Sitting _____
In the PM_____	Twisting right_____	Standing_____	Lifting _____
Bending forward_____	Bending left_____	Coughing_____	Walking_____
Bending backward_____	Bending right_____	Sneezing_____	Running_____

Were any of the above symptoms brought on by or aggravated by a motor vehicle accident, work related accident or other incident we should be aware of? If yes, explain_____

If you were involved in a motor vehicle accident in the last two years, please complete the **MVA form**.

In reference to prior symptoms:

_____I have NOT had prior symptoms similar to my current complaints
_____My current complaints did exist before but were dormant
_____My current complaints already existed but were worsened/aggravated

Has your history contributed to your symptoms:

_____My history HAS contributed to my symptoms
_____My history HAS NOT contributed to my symptoms
_____I am NOT SURE if my history has contributed to my symptoms

Family History – does you or your immediate family suffer from any of the following:

Is there any relevant family history we should be aware of including incidences of the following:

ARTHRITIS	YES / NO WHO_____	ASTHMA/HAYFEVER	YES / NO WHO_____
BACK PAIN/CONDITIONS	YES / NO WHO_____	BURSITIS	YES / NO WHO_____
CANCER	YES / NO WHO_____	DIABETES	YES / NO WHO_____
DISC CONDITIONS	YES / NO WHO_____	EMPHYSEMA	YES / NO WHO_____
EPILEPSY	YES / NO WHO_____	FIRBROMYALGIA	YES / NO WHO_____
HEADACHES	YES / NO WHO_____	HEART CONDITIONS	YES / NO WHO_____
HIGH BLOOD PRESSURE	YES / NO WHO_____	KIDNEY CONDITIONS	YES / NO WHO_____
LIVER CONDITIONS	YES / NO WHO_____	LUNG CONDITIONS	YES / NO WHO_____
NEURITIS	YES / NO WHO_____	SCOLIOSIS	YES / NO WHO_____
STROKE	YES / NO WHO_____	SINUS CONDITIONS	YES / NO WHO_____
INTESTINAL CONDITIONS	YES / NO WHO_____	OTHER _____	WHO_____

Please Circle (C) "Current by any conditions you have now or (P) "Past" the conditions you have had in the past or (I) "Intermittent" for conditions that come and go. If "Not Applicable" circle N/A. Please do not leave any blank.

FIRBROMYALGIA	C P I N/A	IBS	C P I N/A
HIGH BLOOD PRESSURE	C P I N/A	DIARRHEA	C P I N/A
DIZZINESS/FAINTING	C P I N/A	DIGESTIONS PROBS.	C P I N/A
INSOMNIA	C P I N/A	NAUSEA	C P I N/A
MUSCLE TENSION	C P I N/A	FATIGUE	C P I N/A
ULCERS/TYPE? _____	C P I N/A	EYE/VISION PROBS.	C P I N/A
CONSTIPATION	C P I N/A	FEMALE PROBS.	C P I N/A
PROSTATE PROBLEMS.	C P I N/A	DIABETES/TYPE ?_____	C P I N/A
COLD HANDS/FEET	C P I N/A	LOSS OF MEMORY	C P I N/A
NERVOUSNESS	C P I N/A	DEPRESSION	C P I N/A
SWEATY PALMS	C P I N/A	DIFFICULTY BREATHING	C P I N/A
LOSS OF BLADDER CONTROL	C P I N/A	IRRITABILITY	C P I N/A
EAR/HEARING PROBS	C P I N/A	SPEECH DIFFICULTY	C P I N/A
HEART PROBS	C P I N/A	ANXIETY	C P I N/A
FRACTURE/BROKEN BONE	C P I N/A TYPE? _____	CHRONIC FATIGUE SYND.	C P I N/A
HYPERTENSION	C P I N/A	STROKE	C P I N/A

Have you been diagnosed with any condition or are there any conditions not listed above that affect you?

_____

Is there ANY information regarding your general health that the doctor should know about? (ie: past surgeries, hospitalizations, fractures, accidents, etc.?) _____

_____

Are you currently taking any prescription medication, over-the-counter meds or natural supplements such as vitamins or herbs? Please list all below:

Name/Describe	Purpose/Reason	Length of Time Taken

Have you ever suffered from a stroke? Y N Have you ever had spinal surgery? Y N

Have you had any surgery in the past five years? Please include all procedures even knee scoping, dental surgery, etc.?_____

Informed Consent for Treatment

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.
If during the course of care we encounter unusual findings or findings outside our scope of practice, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name_____Signature_____ Date_____

Consent to evaluate and adjust a minor child:

I, _____being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and I give my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle. _____ Signature_____ Date_____

X-Ray Release:

Advance Being Clinic, Dr. Binh Pham and/or their employees, associates or consigns have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous.

Print Name_____Signature_____ Date_____