ADVANCED HEALTH
NATURAL HEALTH IMPROVEMENT CENTER

NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name ____ Date _____________________ Home (____)____-____________

Address ____ Apt. # _______ Work (____)____-____________

City __________________________________ State ____________ Zip ________________ SS# _______ - ____ - ___________

E-mail address: ____

REFERRED BY: ____

Occupation ____ Employer ____

Date of Birth ____________________________ Age __________ Sex: M / F Height ___________ Weight ______________

Overall health (circle one): Excellent / Good / Fair / Poor / Other: ____

Chief complaint (reason you are here): (use separate sheet if more room is needed)

____

Previous treatments for this complaint: ____

____

Other complaints or problems: (use separate sheet if needed)

____

Current medications/drugs being taken: (use separate sheet if needed) _______________________________________

____

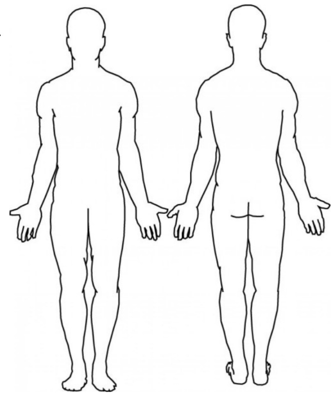
Are you currently under the care of a physician or other health care professionals? YES / NO

(If yes, please give name and date of last visit) ____

Nutritional supplements you are taking: ____

Do you smoke, drink coffee or alcohol? YES / NO

(IF yes indicate how much) Cigarettes _________ Coffee __________ Alcohol __________



When did you symptoms appear? ____

Is this condition getting progressively worse? YES / NO / UNKNOWN

Mark an "x" on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scal from 1 (least pain) to 10 (severe pain) ___________

Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □Shooting

□ Burning □Tingling □ Cramps □ Stiffness □ Swelling □ Other

How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with your □ Work □ Sleep □Daily Routine □ Recreation

Activities or movements that are painful to perform □ Sitting □Standing □Walking □Bending □ Lying Down

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I give Advanced Health Natural Health Improvement Center permission to bill my insurance company for chiropractic services.

SIGNED: ____ **DATE:** ____________________

NEW PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY:

Name ____ Date ____________________

HISTORY:

List any major illnesses (with approx. dates): ____

____

List any surgery or operations with approx . Date: ____

____

Past Accidents or injuries: ____

____

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Marital Status: S M D W Name of Spouse ______________________________________

Describe health of spouse: ______________________________ Number of children if any ____________

Name of Child	AGE	SEX	Any physical conditions or concerns?
____________________	________	M / F	______________________________
____________________	________	M / F	______________________________
____________________	________	M / F	______________________________
____________________	________	M / F	______________________________

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Hearth / Other: ____________________

____

Any household pets or other animals you or family members are in close contact with: ______________________________

____

What can we do to make you happier? ____

____

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SIGNED: ____ **DATE:** ____________________

OFFICE USE ONLY: