ADVANCED PHYSICAL HEALTH
CHIROPRACTIC
Columbia, Missouri

# HEALTH HISTORY FORM

*We welcome you and your family to our clinic. In order to help us better serve you, please complete the following information. We look forward to working with you to build better health and well-being.*

**Patient Information:**

Today's Date: _____

Name (First, Last, Middle Initial): _____
Please call me: _____
Birth Date: ____/____/_____ How Young Are You? _____years ☐Female ☐Male
S/S #: _____ ☐ Married ☐ Single

Cell Phone Number: _____ Secondary Number: _____
Email: _____ Best Time to Reach You: _____
Address:_____
City: _____ State: _____ Zip: _____
Your Occupation: _____Employer: _____

Spouse's Name: _____Spouse's Birth Date: _____
Spouse's Occupation & Employer: _____

Whom may we thank for referring? _____

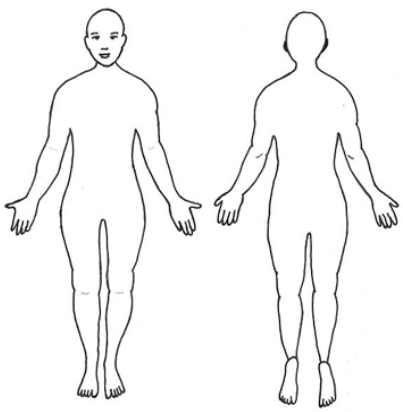
**Emergency Contact**

Name: _____ Relationship: _____
Cell Phone Number: _____

**Insurance:** *If you wish for us to submit to insurance, please present your card to the front desk staff member.*

**Current Health History**

Reason(s) for care:
☐Maintenance ☐Improved Health ☐Problem: _____
Is this condition due to an accident? _____
When did the symptoms appear: _____
On a scale of 1 (least pain) to 10 (severe pain): _____
*Please mark an X on the picture for the area of involvement.*
Is the condition getting progressively worse? **Y/N**
How often do you have this pain? _____% of the time.
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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What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None ☐ Other

Other doctors seen for this condition (please include doctor's name, tests done and prior treatments):
_____
_____
_____

**Date of Last:**
Physical Exam _____Spinal Exam _____
Spinal Imaging (X-ray, MRI, CT, Bone Scan) _____Blood Work _____

Please check any of the following conditions that apply:

| | | | |
|---|---|---|---|
| ____HIV/AIDS | ____Allergies | ____Anemia | ____Arthritis |
| ____Asthma | ____Autism | ____Bleeding Disorders | ____Bronchitis |
| ____Cancer | ____Chronic Colds | ____Diabetes | ____Digestive Problems |
| ____Ear Problems | ____Emphysema | ____Epilepsy | ____Fractures |
| ____Headaches | ____Heart Disease | ____Hepatitis | ____Herniated Disc |
| ____High Cholesterol | ____Kidney Disease | ____Liver Disease | ____Migraines |
| ____Mononucleosis | ____Multiple Sclerosis | ____Osteoporosis | ____Pacemaker |
| ____Parkinson's | ____Pinched Nerve | ____Psychiatric Care | ____Rheumatoid |
| ____Recurring Fevers | ____Reflux | ____Scoliosis | ____Stroke |
| ____Seizures | ____Former Smoker | ____Current Smoker | |

If applicable, number of children: _____ Is it possible you are pregnant? **Y/N**
If yes, due date**:** _____

**Please list any:**
Falls: _____Date(s): _____
Head Injuries: _____Date(s): _____
Fractures: _____Date(s): _____
Surgeries: _____Date(s): _____

For your work responsibilities, are you mostly:☐Sitting ☐Standing ☐Heavy Labor

Current exercise regime: _____

Present prescription drugs/dosage: _____
Over the counter drugs:_____

Family history of significant spinal conditions:
_____
_____
_____

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## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

By signing below, I give my consent for examination and the performance of any tests or procedures needed. The treatment may include chiropractic adjustments and other procedures considered therapeutically diagnostic and appropriate.

Chiropractic is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of back pain, neck pain, headaches, and other neuromusculoskeletal complaints. Although chiropractic has an excellent safety record, no health treatment is completely free of potential adverse effects. The risks associated with chiropractic, however, are very small. Many patients feel immediate relief following chiropractic treatment, but some may sometimes experience mild soreness or aching, just as they do after some forms of exercise. This typically fades within 24 hours. Specifically, neck manipulation is a remarkably safe procedure. Some reports have associated upper high-velocity neck manipulation with a vertebral artery dissection, but the evidence suggests that this type of arterial injury often takes place spontaneously following everyday activities. Patients with this condition may experience neck pain and headache that leads them to seek professional care—often at the office of a doctor of chiropractic or family physician—but that care is not the cause of the injury. The evidence indicates that the incidence of artery injuries associated with high-velocity upper neck manipulation is extremely rare – about 1 case in 5.85 million

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care. I wish to rely on Advanced Physical Health PC and its doctors to make those decisions about my care, based on the facts then known, that they believe are in my best interest. If the patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

## ASSIGNMENT & RELEASE

Assignment & release- by signing below, I authorize Advanced Physical Health PC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly Advanced Physical Health PC and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

_____ _____

Patient Name Printed Date

_____

Signed

_____

Signature of Parent (or Guardian) if minor

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# Electronic Health Records Intake Form

*In compliance with government requirements for EHR programs*

First Name: _____Last Name: _____

Email address: _____

Preferred method of communication (circle one): **Email/Phone/Mail**

DOB: _____ Gender (circle one): **M/F** Preferred Language:

_____

Smoking Status (circle One): **Every Day Smoker/Occasional Smoker/Former Smoker/Never Smoked**

*(CMS requires providers to report both race and ethnicity):*

Race (circle One): **American Indian or Alaska Native/Asian/African American/Caucasian/Native Hawaiian or Pacific Islander/Other/Decline to Answer**

Ethnicity (circle One): **Hispanic or Latino/ Not Hispanic or Latino/Decline to Answer**

Are you currently taking any medications? (Please include over the counter meds)

Medication Name Dosage and Frequency

_____
_____
_____

Do you have medication allergies?

Medication Name Reaction Onset Date Additional Comments

_____
_____
_____

☐ I choose to decline receipt of my clinical summary after every visit *(These summaries are often black as a result of the nature and frequency of chiropractic care)*

Patient signature: _____ Date: _____

Height: _____Weight:_____ Blood Pressure: _____/_____