Advanced Spinal Care

Name_____ Address_____ City_____ Zip_____

Birthday_____ Phone# H_____ C_____ W_____ Marital status_____

Employer_____Address_____

Soc Sec#_____-_____-_____ DL#_____ E-mail:_____

Person to contact in case of emergency: _____ Phone:(___)_____

Who will be responsible for this patient's account? _____ Referred by_____
PAYMENT IS EXPECTED AT THE TIME OF VISIT.

INSURANCE INFORMATION
Please request insurance claim forms if you intend to do your own billing of your insurance.

SYMPTOMS
Please describe your condition_____

Please tell us **when** your condition began_____ What caused your condition?_____

Type of pain: O Sharp O Dull O Throbbing O Numbness O Aching O Shooting
O Burning O Tingling O Cramps O Stiffness O Swelling O Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go?_____

What treatment/s have you received for your condition?
O Medication O Surgery O Physical Therapy O Other_____

How did they work for you? _____

Other Doctors seen for this condition_____ When? _____

Have you ever suffered from TMJ pain? **yes no** Describe **what** makes the pain worse_____

Do you have Head pain? **yes no** Describe **where** and **when** you feel pain_____

Do you have Neck pain? **yes no** Describe the pain or discomfort you feel_____

Low back pain? **yes no** Describe **what** kind of pain you feel_____

Mid-back pain? **yes no** Describe **what** kind of pain you feel and **what** makes it worse_____

Abdomen pain? **yes no** Describe **when** you feel pain and **what** makes it worse_____

Shoulder pain? **yes no** Describe **when** you feel pain and **what** makes it worse_____

Arm and/or Hand pain? **yes no** Describe **what** activity makes it worse_____

Chest pain? **yes no** Describe_____

Leg, or Foot pain? **yes no** Describe **what** activity makes it worse_____

Have you suffered from any nervousness or irritability? **yes no** Describe_____

Have you felt depressed, fatigued, or generally run down? **yes no** Describe_____

Are you suffering from loss of sleep? **yes no** Describe_____

Have you recently experienced a weight gain or loss? **yes no** If so, how much?_____

HEALTH HISTORY

Please check all of the following health concerns that apply to you over the last ten years, even if you think that your answers do not relate to your present health concern.

□ Allergies	□ Depression	□ Kidney Disease	□ Pins & Needles in Legs
□ Anxiety	□ Diarrhea	□ Loss of Balance	□ Ringing in Ears
□ Arthritis	□ Digestive Problems	□ Loss of Smell	□ Sensitivity to Light
□ Asthma	□ Dizziness	□ Loss of Taste	□ Sinus Trouble
□ Back Pain	□ Fainting	□ Menstrual Cramps	□ Skin Conditions
□ Bladder Problems	□ Fatigue	□ Menstrual Irregularity	□ Sleeping Problems
□ Buzzing in Ears	□ Headache	□ Mood Swings	□ Stomach Upset
□ Cancer	□ Heartburn/Acid Reflux	□ Neck Pain/Stiffness	□ Tension
□ Circulatory/Vascular Problems	□ Heart Condition	□ Nervousness	□ Ulcers
□ Cold Feet	□ Hot Flashes	□ Numbness in Fingers	□ Urinary Difficulty
□ Cold Hands	□ Irritability	□ Numbness in Toes	□ Other: _____
□ Cold Sweats	□ Immune System Disorder	□ Osteoporosis	_____
□ Constipation	□ Infertility	□ Pins & Needles in Arms	_____

Please check off any stresses that you experience or have experienced that could cause stress to the nervous system.

PHYSICAL STRESS

O Slips/falls	O Difficult birth (when you were born and/or if you have given birth)
O Desk Job	O Car Accidents
O Hard Labor	O Work Postures
O Unhealthy Weight	O Other: _____
	_____

CHEMICAL STRESS

O Not Enough Water	O Drink Alcohol
O Missed Meals	O Unhealthy/Processed Foods
O Fast Foods	O Work With Chemicals
O Not Enough Fruits/Vegetables	O Pesticides/hormones in Our Food
O Non-prescription Medications	O Prescription Medications
O Smoke	O Other: _____
	_____

MENTAL/EMOTIONAL STRESS

O Finances	O Work
O Relationships	O Unhealthy Thoughts
O Depression	O Loss Of Loved One
O Poor Self Image	O Anger, Guilt, Resentment, Etc.
O Other: _____	
_____	

DAILY HABITS

What type of exercise do you perform? O None O Moderate O Heavy
What do your daily work habits include? _____
What vitamins do you currently take? _____
List all the medication you are taking? _____

WOMEN ONLY

Date of last period_____ **Are you Pregnant? yes no** How many weeks_____

It is your responsibility to give Advanced Spinal Care as accurate information as is possible, so that we may fully understand your condition in order to serve your needs as best as we can. Please sign to verify the accuracy of the information above:

Patient Signature_____ **Date**_____

Thank you!