Comprehensive Health History

Patient Information

Patient Name: _____
(last) *(first)* *(middle initial)*

Address: _____

City: _____ State _____ Zip _____

Home Ph: (____) _____ Cell Ph: (____) _____

Work Ph: (____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

SS#: _____ DOB: _____ Age: _____

Status : □ Single □ Married □Widowed □Divorced □Separated □Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (____) _____ Cell Ph: (____) _____

How Did You Hear About Us?

□ Referral: _____ □ Direct Mail
□ Internet □ Magazine
□ TV □ Other: _____

Insurance Information

Who is responsible for this account? □ Self □ Other: _____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient covered by additional Insurance? □ Yes □ No

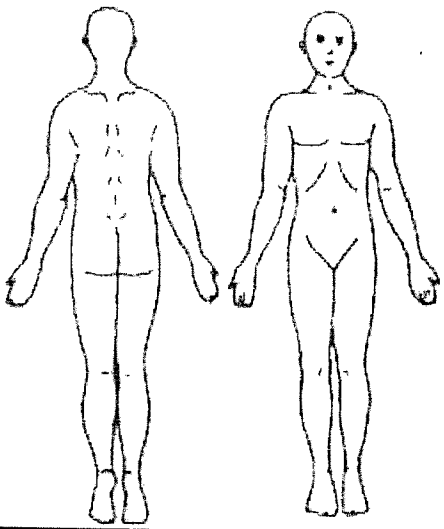
Subscribers Name: _____

DOB: _____ SS#: _____

Relationship to Patient: _____

Insurance Company: _____

Policy # _____ Group # _____



Label on the Diagram the CURRENT Areas of Discomfort:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins&Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Current Condition

If you could erase 3 health problems, what would they be?

1. _____
2. _____
3. _____

Problem #1

When did you 1st notice this problem? _____
Has it occurred before? □ Yes □ No When? _____

Is the condition getting worse? □ Yes □ No □ Unknown

Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause
□ Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

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

What treatment have you received for this problem?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services
□ None □ Other _____

Problem #2

When did you 1st notice this problem? _____
Has it occurred before? □ Yes □ No When? _____

Is the condition getting worse? □ Yes □ No □ Unknown

Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause
□ Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

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

What treatment have you received for this problem?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services
□ None □ Other _____

Problem #3

When did you 1st notice this problem? _____
Has it occurred before? □ Yes □ No When? _____

Is the condition getting worse? □ Yes □ No □ Unknown

Is the Condition: □ Auto Related □ Job Related □ Home Injury
□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause
□ Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

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

What treatment have you received for this problem?
□ Medication □ Surgery □ Physical Therapy □ Chiropractic Services
□ None □ Other _____

If Auto or Job Related:
To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Work Comp □ Other _____
Attorney Name: *(if applicable)* _____

Current Medications

Medication	Dosage/How Long	For What Condition?

Medication Allergies: _____

Reaction? _____

Supplement Allergies: _____

Reaction? _____

Food Allergies: _____

Reaction? _____

Do you have any surgical devices in your body? *(ie screws, pins, plates, etc)*

□ Yes □ No If yes, where located _____

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No Describe: _____

_____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin? □ Yes □ No

Tylenol? □ Yes □ No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)? □ Yes □ No

Frequent Antibiotics (> 3 times a year) □ Yes □ No

Long Term Antibiotics □ Yes □ No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers) □ Yes □ No

Work Activity

Labor Activity:

□ Light □ Moderate □ Heavy □ Sedentary

Work Activity Postures:

□ Bending □ Climbing □ Kneeling □ Pulling
□ Pushing □ Reaching □ Sitting □ Standing
□ Twisting □ Walking □ Computer □ Repetitive

Work Activity Level:

□ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed

Hours per week _____ Mostly □ Sitting □ Walking □ Standing

Work Environment:

□ Difficult □ Enjoyable □ Relaxed □ Stressful

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** – no regular physical activity with a sit-down job.

□ **Light Activity** – no organized physical activity during leisure time.

□ **Moderate Activity** – occasionally involved in activities (2-3x/week)

□ **Heavy Activity** – consistent lifting, stair climbing, heavy construction, etc., or regular participation in active sports. (3-5x/week)

□ **Vigorous Activity** – participation in extensive physical exercise for at least 60 minutes per session (4-7x/week)

Please check all that apply:

□ Tobacco – Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? _____

□ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have previously used recreational drugs? □ Yes □ No

If yes, what types/method (IV, inhaled, smoked, etc) _____

Allergies

Do you have a history of allergies? Y N

If so for how long? _____

What season(s) do your allergies bother you the most?

Spring Summer Fall Winter All Year

Common Allergy Symptoms: Please rate by severity

0=None 1=Mild 2=Moderate/Severe

Nasal Congestion	0	1	2
Sneezing	0	1	2
Coughing	0	1	2
Wheezing	0	1	2
Asthma	0	1	2
Watery, Itchy Eyes	0	1	2
Sinus or Ear Infections	0	1	2
Sore Throat	0	1	2
Trouble Breathing while sleeping	0	1	2
Fatigue	0	1	2
Headaches	0	1	2
Itchy Skin	0	1	2
Eczema	0	1	2
Hives	0	1	2

Do you have a history of heart disease? Y N

Do you have a history of asthma or lung disease? Y N

Have you ever been to an emergency room, urgent care or hospital due to an allergic reaction? Y N

Please list any know allergies and the symptoms they cause:

_____

_____

_____

_____

_____

Patient Name _____ Patient Signature _____ Date _____

Medical History

Please check all that apply / Indicate When and any Comments/Results

Surgeries (Indicate what year)

___ N/A
___ Appendectomy
___ Cardiac Bypass
___ C-Section
___ Cosmetic
___ Gall Bladder
___ Implants
___ Lasik
___ Tonsillectomy
___ None Reported
___ Bunionectomy
___ Cataracts
___ Carpal Tunnel
___ Ear Tubes
___ Hysterectomy
___ Knee
___ Spinal Fusion
___ Wisdom Discectomy

Injuries

___ Back Injury
___ Head Injury
___ Neck Injury
___ Soft Tissue
___ Broken Bones/Fractures
___ Industrial
___ Severe Fall
___ Other

Medical History - Past or Present Illnesses

Please check all that apply (past or present) / Circle **CURRENT** Conditions

___ ADD
___ Alzheimer's
___ Arthritis
___ Bleeding Disorders
___ Bronchitis
___ Cerebral Palsy
___ Cholera
___ Constipation
___ Diabetes (*insulin*)
___ Eczema
___ Fetal Drug Exposure
___ Gallstones
___ Gonorrhea
___ Heart Disease
___ Herniated Disk
___ Hormone Replacement
___ IBS (*Irritable Bowel Syndrome*)
___ Lung Disease
___ Measles
___ Multiple Sclerosis
___ Pacemaker
___ Pneumonia
___ Prosthesis
___ Rheumatic Fever
___ Sickle Cell Anemia
___ STD
___ Thyroid Problems
___ Typhoid Fever
___ Vertigo
___ AIDS/HIV
___ Anemia
___ Asthma
___ Blood Clot
___ Bulimia
___ Chemical Dependency
___ Chronic Fatigue Syndrome
___ CVA (Stroke)
___ Diabetes (*non insulin*)
___ Emphysema
___ Fibromyalgia
___ German Measles
___ Gout
___ Heart Failure
___ Herpes/Lesions/Shingles
___ Hypertension
___ Jaundice
___ Lupus Erythema (*Discoid*)
___ Migraine Headaches
___ Mumps
___ Parkinson's Disease
___ Polio
___ Psoriasis
___ Scarlet Fever
___ Sinusitis
___ Stroke
___ Tonsilitis
___ Ulcers
___ Whooping Cough
___ Alcoholism
___ Anorexia
___ Atopic Dermatitis
___ Blood Transfusion
___ Cancer
___ Chest Pain
___ Crohn's/Colitis
___ Cystic Kidney Disease
___ Ear Infections
___ Epilepsy/Convulsions
___ Fractures
___ Glaucoma
___ Headaches
___ Hepatitis
___ High Blood Pressure
___ Hypoglycemic
___ Kidney Stones
___ Lupus Erythema (Systemic)
___ Miscarriage
___ Nervous Breakdown
___ Pinched Nerve
___ Pregnancy
___ Psychiatric Care
___ Scoliosis
___ Sleep Apnea
___ Suicide Attempt(s)
___ Tuberculosis
___ Unspec. Pleural Effusion
___ Other: _____
___ Allergies
___ Appendicitis
___ Bed Wetting
___ Breast Lump
___ Cataracts
___ Chicken Pox
___ CRPS (RSD)
___ Depression
___ Eating Disorder
___ Eye Problems
___ Gallbladder Disorder
___ Goiter
___ Heart Attack
___ Hernia
___ High Cholesterol
___ Influenza Pneumonia
___ Liver Disease
___ Malaria
___ Mononucleosis
___ Osteoporosis
___ Pleurisy
___ Prostate Problems
___ Rheumatoid Arthritis
___ Seizure Disorder
___ Spina Bifida
___ Swelling Feet
___ Tumors, Growths
___ Vaginal Infections

Patient Name _____ Patient Signature _____ Date_____

Family Health History

Check all family members that apply	Mother	Father	Brother (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (ex: Rheumatoid Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (ex: Lupus, Hashimotos)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as Alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Patient Name _____ Patient Signature _____ Date_____

Review of Symptoms

Indicated which of the below you have experienced in the **last 1-2 months.**
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Ears/Nose
Decreased Hearing 1 2 3 4 5
Ear Drainage 1 2 3 4 5
Ear Pain/Ear Infection 1 2 3 4 5
Frequent Sneezing 1 2 3 4 5
Headaches 1 2 3 4 5
Hayfever 1 2 3 4 5
Itchy/Watery Eyes 1 2 3 4 5
Loss of Smell 1 2 3 4 5
Nose Bleeds 1 2 3 4 5
Nose Drainage/Runny 1 2 3 4 5
Ringing in Ears 1 2 3 4 5
Snoring 1 2 3 4 5
Stuffy Nose 1 2 3 4 5
TMJ 1 2 3 4 5

Eyes/Vision
Blindness 1 2 3 4 5
Blurred/Double Vision 1 2 3 4 5
Cataracts 1 2 3 4 5
Eye Pain 1 2 3 4 5
Field Cuts 1 2 3 4 5
Glaucoma 1 2 3 4 5
Itching 1 2 3 4 5
Photophobia 1 2 3 4 5
Tearing 1 2 3 4 5
Wear Glasses/Contacts 1 2 3 4 5

Skin
Excessive Sweating 1 2 3 4 5
Eczema 1 2 3 4 5
Dryness 1 2 3 4 5
Hives 1 2 3 4 5
Itching 1 2 3 4 5
Lumps 1 2 3 4 5
Nail Texture/
Skin Color Changes 1 2 3 4 5
Rashes 1 2 3 4 5
Skin Lesions 1 2 3 4 5
Varicosities 1 2 3 4 5

Cardiovascular
Angina 1 2 3 4 5
Chest Pain 1 2 3 4 5
Claudication (leg pain/ache) 1 2 3 4 5
Congestive Heart Failure 1 2 3 4 5
Coronary Artery Disease 1 2 3 4 5
Difficulty Breathing Lying 1 2 3 4 5
Heart Murmur 1 2 3 4 5
Heart Problems 1 2 3 4 5
High Blood Press (no meds) 1 2 3 4 5
High Blood Press (on meds) 1 2 3 4 5
Low Blood Pressure 1 2 3 4 5
Pacemaker/Defibrillator 1 2 3 4 5
Palpitations 1 2 3 4 5
Shortness of Breath
with Exertion/Exercise 1 2 3 4 5
Swelling of Legs 1 2 3 4 5
Ulcers 1 2 3 4 5
Varicose Veins 1 2 3 4 5
Waking at Night -
Shortness of Breath 1 2 3 4 5

Muscular/Skeletal
Ankle/Foot Pain 1 2 3 4 5
(Circle all that apply)
Popping, Clicking, Weakness, Stiffness

Arthritis 1 2 3 4 5
Balance Problems

Elbow Pain 1 2 3 4 5
(Circle all that apply)
Popping, Clicking, Weakness, Stiffness

Fibromyalgia 1 2 3 4 5

Hip Pain 1 2 3 4 5
(Circle all that apply)
Popping, Clicking, Weakness, Stiffness

Joint Pain 1 2 3 4 5

Knee Pain 1 2 3 4 5
(Circle all that apply)
Popping, Clicking, Weakness, Stiffness

Low Back Pain 1 2 3 4 5
Muscle Aches 1 2 3 4 5
Muscle Cramping
Muscle Stiffness(in a.m.)
Neck Pain 1 2 3 4 5
Pain Between Shoulder 1 2 3 4 5
Pain Wakens You 1 2 3 4 5

Shoulder Pain 1 2 3 4 5
(Circle all that apply)
Popping, Clicking, Weakness, Stiffness

Weakness in Arms/Legs 1 2 3 4 5

Wrist/Hand Pain 1 2 3 4 5
(Circle all that apply)
Popping, Clicking, Weakness, Stiffness

Gastrointestinal
Abdominal Pain/Cramps 1 2 3 4 5
Abnormal Stool 1 2 3 4 5
Belching 1 2 3 4 5
Black/Tarry Stools 1 2 3 4 5
Bloating/Gas 1 2 3 4 5
Change in Appetite 1 2 3 4 5
Change in Bowel Habit 1 2 3 4 5
Constipation 1 2 3 4 5
Crohn's Disease 1 2 3 4 5
Diarrhea 1 2 3 4 5
Hemorrhoids 1 2 3 4 5
Indigestion 1 2 3 4 5
Jaundice 1 2 3 4 5
Rectal Bleeding 1 2 3 4 5
Reflux/Heartburn 1 2 3 4 5
Nausea/Vomiting 1 2 3 4 5
Vomiting Blood 1 2 3 4 5

Throat/Respiratory
Asthma/ Wheezing 1 2 3 4 5
Bleeding Gums 1 2 3 4 5
Chronic Cough 1 2 3 4 5
Coughing up Blood 1 2 3 4 5
Chest Congestion 1 2 3 4 5
Dentures 1 2 3 4 5
Difficulty Swallowing 1 2 3 4 5
Hoarseness 1 2 3 4 5
Shortness of Breath 1 2 3 4 5
Sore Throat 1 2 3 4 5

Hematologic
Anemia 1 2 3 4 5
Ease of Bleeding 1 2 3 4 5
Blood Clotting 1 2 3 4 5
Blood Transfusion 1 2 3 4 5
Bruise Easily 1 2 3 4 5
Lymph Node Swelling 1 2 3 4 5

Neurological
Dizziness 1 2 3 4 5
Facial/Limb Weakness 1 2 3 4 5
Fainting/
Loss of Consciousness 1 2 3 4 5
Headaches 1 2 3 4 5
Loss of Memory 1 2 3 4 5
Migraines 1 2 3 4 5
Numbness 1 2 3 4 5
Seizures 1 2 3 4 5
Sleep Disturbance 1 2 3 4 5
Slurred Speech 1 2 3 4 5
Stroke 1 2 3 4 5
Tingling 1 2 3 4 5
Tremor 1 2 3 4 5
Unsteadiness of Gait 1 2 3 4 5

Mental/Emotional
Anxiety/Panic 1 2 3 4 5
Behavioral Change 1 2 3 4 5
Bi-Polar Disorder 1 2 3 4 5
Blackouts/Amnesia 1 2 3 4 5
Clumsy 1 2 3 4 5
Confusion 1 2 3 4 5
Cry Often 1 2 3 4 5
Daytime Sleepiness 1 2 3 4 5
Convulsions 1 2 3 4 5
Depression 1 2 3 4 5
Emotional Numbness 1 2 3 4 5
Foggy Thinking 1 2 3 4 5
Forgetfulness 1 2 3 4 5
Have Considered Suicide 1 2 3 4 5
Have Hallucinations 1 2 3 4 5
Have Overused Alcohol 1 2 3 4 5
Hyperactive 1 2 3 4 5
Insecure 1 2 3 4 5
Insomnia 1 2 3 4 5
Jittery 1 2 3 4 5
Memory Loss 1 2 3 4 5
Mood Swings/Irritability 1 2 3 4 5
Nervous Breakdown 1 2 3 4 5
Grumpiness 1 2 3 4 5
Poor Concentration 1 2 3 4 5
Restless Leg Syndrome 1 2 3 4 5
Shy 1 2 3 4 5
Uses Tranquilizers 1 2 3 4 5
Withdrawn 1 2 3 4 5
Workaholic 1 2 3 4 5

Urinary
Blood in Urine 1 2 3 4 5
Burning or Pain 1 2 3 4 5
Frequency 1 2 3 4 5
Incontinence 1 2 3 4 5
Kidney Stones 1 2 3 4 5
Urgency 1 2 3 4 5

Endocrine
Abnormal Urination 1 2 3 4 5
Change in Appetite 1 2 3 4 5
Decreased Endurance 1 2 3 4 5
Diabetes 1 2 3 4 5
Excessive Hunger 1 2 3 4 5
Excessive Thirst 1 2 3 4 5
Fatigue/Drowsiness 1 2 3 4 5
Feel "Burned Out" 1 2 3 4 5
Goiter 1 2 3 4 5
Hair Loss/Hair Growth 1 2 3 4 5
Hot Flashes/Night Sweats 1 2 3 4 5
Hypo/Hyper Thyroid 1 2 3 4 5
Inability to Lose Weight 1 2 3 4 5
Poor Sleep 1 2 3 4 5
Voice Changes 1 2 3 4 5
Weight Loss/Gain 1 2 3 4 5

Reproductive
Burning Urination 1 2 3 4 5
Cramps 1 2 3 4 5
Frequent Urination 1 2 3 4 5
Hormone Therapy 1 2 3 4 5
Itching/Rash 1 2 3 4 5
Decreased Libido 1 2 3 4 5
Mood Swings 1 2 3 4 5
STI's 1 2 3 4 5
Infertility

Males Only:
Have you had a PSA? ☐ Yes ☐ No
Levels? ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

Erectile Dysfunction 1 2 3 4 5
Genital Pain 1 2 3 4 5
Hernia 1 2 3 4 5
Impotence 1 2 3 4 5
Urination at Night 1 2 3 4 5
Prostate Enlargement 1 2 3 4 5
Prostate Infection 1 2 3 4 5

Females Only:
Heavy Bleeding 1 2 3 4 5
Hot Flashes 1 2 3 4 5
Irregular Menstruation 1 2 3 4 5
Ovarian Cysts 1 2 3 4 5
Pain During Sex 1 2 3 4 5
Painful Periods 1 2 3 4 5
Vaginal Discharge 1 2 3 4 5
Vaginal Dryness 1 2 3 4 5

Notes:

_____

_____

_____

Patient Name _____ Patient Signature _____ Date_____

ADVANCED MEDICAL CONSENT TO TREAT

I hereby request and consent to the performance of spinal manipulation and manual therapy techniques and other physical rehabilitation procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the health care staff of Advanced Medical/Living Wellness and/or other licensed doctors of chiropractic who now or in the future work in this facility.

I have had an opportunity to discuss with a registered or licensed health care provider, the nature and purpose of diagnostic or treatment procedures. I understand that results are not guaranteed.

I understand and am informed that, in the practice of medicine and in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) f)or which I seek treatment.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____

Relationship to Patient

Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay LIVING WELLNESS/ADVANCED MEDICAL, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that *HAVE BEEN* OR *WILL BE* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Print Name of Patient, Parent, Guardian or Personal Representative

Patient Name _____ Patient Signature _____ Date_____

Advanced Medical Center
Integrated Health

PATIENT-PROVIDER ASSESSMENT FORM

Today's Date			
First Name	Last Name	MI	Phone #
Insurance Company	Patient ID / Member ID		
Gender (Select One) Male Female	Height	Weight	Birthday	Age

Are you pregnant? **YES NO** Do you have metal plates/pins in your body? **YES NO** Do you have a pacemaker? **YES NO**
Do you have a pain or insulin pump? **YES NO** Do you have any electrical or metal implants or sensors of any kind? **YES NO**
Please answer the following questions to the best of your ability.

SECTION 1 — *Regarding your health*

[1A] Have you ever experienced any of the following cardiovascular diseases or symptoms?

	YES		YES
Hypertension *(high blood pressure)* ?		Pain in upper back (thoracicalgia)?	
Peripheral Vascular Disease?		Pain in lower back (lumbago)?	
Edema (swelling in arms and/or legs)?		Pain in neck (cervicalgia)?	
Sacroilitis?		Cervical Disc Degeneration?	
Thoracic Disc Degeneration?		Lumbar Disc Degeneration?	

[1B] Have you ever experienced any of the following cardiovascular conditions or symptoms?

Diabetes I with neurological symptoms?		Diabetes II with neurological symptoms?	
Do you experience hyperhidrosis (Excessive sweating)?		Do you ever experience a rapid heart rate *(Tachycardia)* ?	
Do you ever stand up and get dizzy and/or light headed?		Do you ever notice a tingling/numbness feeling in your fingers or limbs?	
Reflex Dystrophy?		Reflex Sympathetic Dystrophy?	
Do you have hypotension *(very low blood pressure)* ?		Peripheral Neuropathy?	
Do you ever experience pain in your arms and/or legs?			

SECTION 2 — *Regarding your personal and family health history*

Do you smoke or have you smoked?		Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD)?	
Do you have diabetes?			
Do you have high cholesterol?		Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)?	
Do you have a history of CVA or TIA?			

Patient Signature	Physician Signature

FOR OFFICE USE ONLY	Continuous BP (XXX/XX mmHg) BP1: _____ BP2: _____ BP3: _____

NAME:_____ DATE:_____

PATIENT ID:_____

	Frequency of Pain				Quality of Discomfort											How does Movement Effect it?			Rate from 1-10	What % of the Day is it noticed?	Since your last visit		
	Continuous	Intermittent	Occasional	Numerous	Dullness	Sharpness	Stiffness	Tightness	Achiness	Burning	Stabbing	Throbbing	Mild	Moderate	Severe	Better	Worse	Same	Rate from 1-10	What % of the Day is it noticed?	Better	Worse	Same
Headache																							
Neck																							
Upper Back																							
Mid Back																							
Low Back																							
Right																							
Shoulder																							
Arm																							
Elbow																							
Wrist/Hand																							
Hip																							
Knee																							
Ankle/Foot																							
Left																							
Shoulder																							
Arm																							
Elbow																							
Wrist/Hand																							
Hip																							
Knee																							
Ankle/Foot																							

PATIENT SIGNATURE:_____ DATE_____

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003 however many of the policies have been in place in this practice for years.

There are rules and restrictions on who may see or be notified of your Protected Health Information(PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically included the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this via telephone, email, text, U.S. mail, etc. We may send you other communications informing you of changes to office policy and new technology that you may find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.