Advanced Healing Center of Orange

630 S. Glassell St. #103 | Orange, CA 92866
714-639-4360
www.advancedhealing.com

Date:_____

Name:_____
First Name Middle Initial Last Name

Address_____

City_____State_____Zip_____

Home Phone # ( )_____Cell # ( )_____

Work # ( )_____E-mail address_____

SS#_____ Birthday_____ Age_____

Occupation_____Employer_____

Marital Status ☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed Spouse's Name_____

Children's names and ages_____

Emergency contact: Name_____
First Name Last Name

Relationship_____ Phone # ( )_____

What Brings You Here?

Have you ever had chiropractic care before? ☐ No ☐ Yes

If yes, please tell us the Doctor's name _____

How did you find out about our office? _____

Patient History

Give a brief detailed description of the problem you are currently experiencing:

_____

_____

_____

How long have you had this condition? _____ is it getting worse? ☐ Yes ☐ No

_____

Does it bother you during (check appropriate box): ☐ work, ☐ sleep, ☐ exercise, ☐ other:

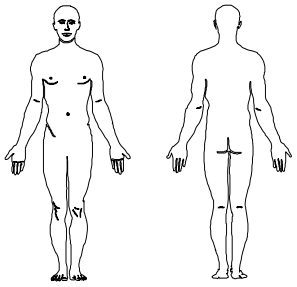
_____

What seemed to be the initial cause:

_____

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

Mark an X on the picture where you continue to have pain.



Type of pain ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ swelling
☐ aching ☐ stiffness ☐ tingling ☐ burning ☐ other

Are your symptoms affected by ☐ sitting ☐ standing
☐ walking ☐ bending ☐ lying down ☐ weather

Accident Information

Is this appointment related to ☐ work ☐ sports ☐ auto accident
☐ personal injury ☐ other_____

When did the incident occur?_____ Where?_____

Attorney (if applicable) _____Phone# ( )_____

Are you receiving care from other health professionals? ☐ No ☐ Yes

Health History

Name of your primary Physician _____ Phone # ( )_____

Date of Last Physical Examination _____

Have You Ever Suffered From:	YES	NO		YES	NO
1. Dizziness	☐	☐	7. Neuritis	☐	☐
2. Backaches	☐	☐	8. Digestive Disorders	☐	☐
3. Heart Trouble	☐	☐	9. Anemia	☐	☐
4. Tuberculosis	☐	☐	10. Nervousness	☐	☐
5. Arthritis	☐	☐	11. Sinus Trouble	☐	☐
6. Headaches	☐	☐	12. Asthma	☐	☐

Past Health History

Have you. . .	Yes	No	If yes, include date & provider seen
…been hospitalized in the last 5 years?	☐	☐	_____
…had any mental disorders?	☐	☐	_____
…had any broken bones?	☐	☐	_____
…been diagnosed with Diabetes Type I ____ or Type II____	☐	☐	_____
…been treated for any other condition/s?	☐	☐	_____

Medications

What medications are you currently taking? Include vitamins, herbs, minerals. . .

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by

_____
-
_____
-
_____
-
_____
-
_____
-
_____
-

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current/Every Day Smoker
☐ Current Some Day Smoker

Do you have allergies? ☐ Food ☐ Environmental ☐ Medication

List Type of Allergy and Reaction

_____

_____

_____

_____

Family history if any blood relative has had any of the following conditions, please check and indicate which relative(s)

☐ Alcoholism_____	☐ Cancer_____	☐ High blood pressure_____
☐ Anemia_____	☐ Diabetes_____	☐ High cholesterol_____
☐ Arteriosclerosis_____	☐ Emphysema_____	☐ Multiple sclerosis_____
☐ Arthritis_____	☐ Epilepsy_____	☐ Osteoporosis_____
☐ Asthma_____	☐ Glaucoma_____	☐ Stroke_____
☐ Bleed easily_____	☐ Heart disease_____	☐ Thyroid disease_____

Financial Responsibility

Who is responsible for payment?_____
Insurance Co. Name_____Group Policy #_____
Insured's name_____Insured's Social Security#_____
Relation_____Date of Birth_____Employer_____

The above is accurate to the best of my knowledge:

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Patient Signature: _____ _____ Date: _____