Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one) **Date**________________________________

First Name: ______________________ **Middle Initial:** ______ **Last Name:** __________________________

Address Line 1: ____

Address Line 2: ____

City: ______________________________ **State:** _________________ **Zip Code:** _________________

Home Phone: (______)_________-_____________ **Work Phone:** (________)_________-_______________

Cell Phone: (______)_________-_____________

Date of Birth: ______/______/_______**Sex:** ☐Male ☐Female **Email:** _________________________________

Social Security Number: _________-______-_____________ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Responsible Party/Spouse/Primary Insurance Data

Is your spouse/responsible party a patient in the clinic? ☐Yes ☐ No

First Name: __________________________ **Middle Initial:** ______ **Last Name:** ________________________

DOB: ____/____/_______**Home/Cell phone:** (____)_____-_________ **Work Phone:** (____)____-___________
(for insurance only)

Employer Data

Name: ____

Address Line 1: ____________________________________

Address Line 2: ____________________________________

City: ______________________________ **State:** ___________________ **Zip Code:** __________________

Emergency Contact

Contact Name:_____________________________________**Relationship:** __________________________

Contact Phone: (________) _________-_______________

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Is it okay to call you at work?

❑ Yes ❑ No

Who may we THANK for referring you to our office?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Internet' please indicate which internet site:

__________________________ __________________________ __________________________ __________________________

If you selected 'family member', 'friend', or 'physician' please enter their name below:

____

If you selected 'other' please describe

____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionally	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day		❑	❑

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years ❑ Under 10 years ❑ Under 19 years

Female Children:

❑ Under 6 years ❑ Under 10 years ❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor

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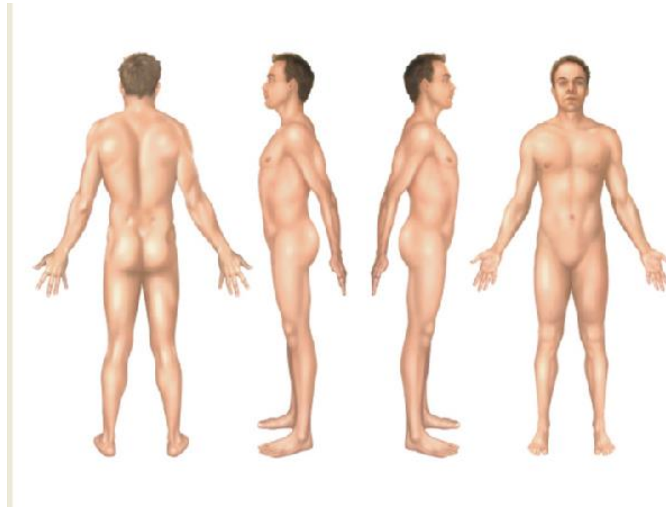
By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:____

____

When did your symptoms start? **Month**_____________________ **Day**_________________ **Year**________________

How did your symptoms begin?____

____

Last Physical Exam____________________ **PAP Exam**_____________ **Abnormals**_____________________________

Mamogram______________________

Prostate Exam_______________________ **Abnormal Findings**____

How often do you experience your symptoms?

❑ Constantly (76-100% of the day)
❑ Frequently (51-75% of the day)
❑ Occasionally (26-50% of the day)
❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

❑ Sharp
❑ Dull ache
❑ Numb
❑ Shooting
❑ Burning
❑ Tingling
❑ Stabbing

How are your symptoms changing?

❑ Getting better
❑ Not changing
❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

❑ 0 None
❑ 1
❑ 2
❑ 3
❑ 4
❑ 5
❑ 6
❑ 7
❑ 8
❑ 9
❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

❑ Not at all
❑ A little bit
❑ Moderately
❑ Quite a bit
❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

❑ All of the time
❑ Most of the time
❑ Some of the time
❑ A little of the time
❑ None of the time

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In general, would you say your overall health right now is…

❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

Who have you seen for your symptoms:

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What treatment did you receive for your symptoms?

❑ Adjustments ❑ Physical Therapy ❑ Medication ❑ Surgery
❑ Other

When did you receive this treatment?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

What tests have you had for your symptoms?

❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

When were these tests done?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

Have you had similar symptoms in the past?

❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What is your occupation?

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

List all medications and prescribing physician:____

____

____

____

____

____

Thank you. Please complete the last few pages and return to the front desk.

PREFERRED CONTACT AUTHORIZATION

The privacy of your protected health information is of utmost importance to us. As such, we wish to contact you in the most efficient and effective manner as possible. Please help us by completing the following information.

I, ______________________________, authorize representatives of Avanti Health to contact me regarding appointments, payment information, prescription refills, or general health, utilizing the following methods. If I wish for certain information to be omitted on messages or call screening, I will check the appropriate box and provide instruction in the area provided below.

Best/preferred method to reach you: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email

Can we contact/leave a message on your home Phone? ❑ Yes ❑ No ❑ See instructions below

Can we contact/leave a message on your cell phone? ❑ Yes ❑ No ❑ See instructions below

Can we contact/leave a message on your work phone? ❑ Yes ❑ No ❑ See instructions below

Can we contact you via email? ❑ Yes ❑ No ❑ See instructions below
Note: only general/appointment information will be emailed.

Instructions: ____

____

____

CONSENT TO SHARE PROTECTED INFORMATION (OPTIONAL)

I give permission to the representatives of Avanti Health, to share my protected information regarding:

❑ Appointments ❑ Payments/Insurance ❑ General Health ❑ Prescription Information

With the following person(s):

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Please sign below:

______________________ ______________________
Patient Name (print) Date

____
Patient Signature

______________________ ______________________
Guardian Signature Date

______________________ ______________________
Guardian Name Relationship to Patient

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS AND PRIVACY NOTICE

I, ______________________________________, consent to Avanti Health (Avanti) for use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for Avanti general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that Avanti diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by Avanti, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of Avanti, but that Avanti is not required to agree to these restrictions. However, if Avanti agrees to a restriction that I request, the restriction is binding on Avanti.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or Avanti has acted in reliance on this consent.

I have been given the opportunity to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. This document is attached to the clipboard used for new patient intake. Please notify our front desk if you wish to have a copy of our Notice of Privacy Practices.

By way of signature, I provide Avanti Health with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

I have read the Privacy Notice and understand my rights contained in the notice.

Patient Name (print)	Date
Patient Signature	
Guardian Signature	Date
Guardian Name	Relationship to Patient