ADVANCE HEALTH SERVICES
PATIENT INFORMATION

Date_____

Name _____Age_____ Birth Date _____ Marital Status: S M W D

Address_____ Apt.# _____City _____State_____ Zip_____

Home Phone_____Work Phone _____Cell Phone _____

Best Place to Reach You (Home Work Cell)

Email address for monthly newsletter_____Occupation_____

Employed by _____ SSN# _____

Primary Physician_____

Phone #/Address_____

Emergency Contact _____Phone Number _____

CHECK OFF ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE EXPERIENCED SINCE THE ACCIDENT :

- ☐ Low Back Pain
- ☐ Pain between Shoulder Blades
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Muscle pain
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Pain in the legs
- ☐ Pain in the feet
- ☐ Tired/Fatigued
- ☐ Difficulty Sleeping
- ☐ Pain in the Shoulders
- ☐ Pain in the Hands
- ☐ Pain in the knees

OTHER (explain)

_____

Is there anything you can do that makes it feel better?

_____

What activities/movements are guaranteed to make it worse?

_____

Please describe the Quality of the pain. (Sharp, Dull, Achy, Shooting, Stabbing, Numb, Tingling, etc...)

_____

Have you seen another Doctor for this problem? Y/N if yes, who/when.

_____

Where you taken to the hospital? Y/N Name of Hospital?

_____

Have you missed work? Y/N If yes how long?

How Serious Do You Think Your Problem Is? (Circle One) MINIMAL SLIGHT MODERATE SEVERE EXTREME

DOES THIS CAUSE YOU TO BE:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt sleep
- ☐ Restricted in your daily activities

DOES THIS EFFECT YOUR WORK:

- ☐ Decision making
- ☐ Poor attitude
- ☐ Decreased productivity
- ☐ Exhausted at the end of the day
- ☐ Unable to work long hours

DOES THIS EFECT YOUR LIFE:

- ☐ Lose patience with spouse/children
- ☐ Restricted household duties
- ☐ Hinders ability to exercise or sports
- ☐ Interferes with ability to do hobbies or other activities

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What have you tried to help relieve/get rid of this problem and how much did it help? (circle appropriately)

- ❖ Medications... Helped: Little Some Much
- ❖ Physical Therapy...Helped: Little Some Much
- ❖ Chiropractic... Helped: Little Some Much
- ❖ Exercise... Helped: Little Some Much
- ❖ Nutrition... Helped: Little Some Much
- ❖ Stretching... Helped: Little Some Much

How Serious Do You Think Your Problem Is? (Circle One) MINIMAL SLIGHT MODERATE SEVERE EXTREME

Health Insurance:_____ Policy #_____
Group# _____ Phone#_____

Patient_____ ADVANCE HEALTH SERVICES
REVIEW OF SYSTEMS Date_____

Have you had ANY of the following conditions in the past 12 months? (mark X if yes, C if currently)

General: Fainting___ Fatigue___ Fever___ Headache___ Allergy___(to what?)_____
Sudden Weight Loss or Gain___ Loss of sleep___ Rashes___ Itching___

Diseases/Conditions: Anemia___ Arthritis___ Alcoholism___ Bleeding Disorder___ Cancer___
Diabetes___ Depression___ Epilepsy___ Glaucoma___ HIV___ Kidney Disease___
Liver Disease___ Pneumonia___ Swollen Glands___ Hyper/hypo Thyroid___

Ear/Eyes/Nose/Throat: Blurred Vision___ Eye Pain___ Hearing Loss___ Ear Pain___
Nose Bleeds___ Sinus Problems___ Sore Throats___ Difficulty Swallowing___

Cardiovascular: High Blood Pressure___ Low Blood Pressure___ Chest Pain___ Rapid Heart Beat___
Stroke___ Ankle Swelling___ Aortic Aneurysm___ Bruise Easily___ High Cholesterol___

Respiratory: Difficulty Breathing___ Chronic Coughing___ Coughing/Sitting up Blood___ Asthma___

Gastro-Intestinal: Abdominal Pain___ Constipation___ Diarrhea___ Nausea___ Vomiting___
Bloating___ Loss of Appetite___ Rectal Bleeding___ Changes in Color of Stool___

Genito-Urinary: Blood in Urine___ Frequent Urination___ Painful Urination___ Kidney Infection___

For Men Only: Lump in Testicles___ Penis Discharge___ Prostate Problems___

For Women Only: Menstrual Cramps___ Excessive Menstrual Flow___ Irregular Cycle___
Birth Control Pills___ Abnormal Pap Smear___ Hot Flashes___ Are you Pregnant? ___

Muscle/Joint/Bone: Spinal Curvature/Scoliosis___ Swollen Joints___ Stiff Neck___ Muscle Pain___
Neck Pain___ Pain Between Shoulders___ Lower Back Pain___ Arm/Leg Pain___

Neurologic: Seizures___ Dizziness___ Numbness/Tingling___ Weakness___ Speech Difficulty___
Loss of Coordination/Balance___ Hand Trembling___ Memory Loss___

Social History: Do you Smoke? ____ Drink Alcohol? _____ Exercise? _____ Take vitamins? _____

Family History: Any history of Diabetes, Heart Disease, Cancer or Arthritis in your family? _____
Mother_____ Father_____ Siblings_____

Previous Care:
Have you been treated by a Physician for any condition in the past 12 months? _____Yes _____No

Describe Condition_____ Date of Last Physical Exam_____

Taking any Medication? _____ What kind? _____

Allergic to any Medication? _____ What kind? _____

Any Past Surgeries? _____

Advance Health Services

It is the practice of this office to provide physical therapy care in an "open therapy" environment. **"Open therapy"** involves several patients being seen in the same therapy area at the same time. Some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patients histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open therapy environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to have therapy in an open therapy environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from our office or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____ _____ _____

Name (printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I _____ have read a copy of Advance Health Services Notice of Patient Privacy Practices.

_____ _____

Signature of Patient or Parent or Legal Guardian Date

Advance Health Services

TERMS OF ACCEPTANCE AND CONSENT FOR CARE

We will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, massage therapy, chiropractic care, and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

The primary focus of chiropractic care is the detection and correction of vertebral subluxation. This is the misalignment of one or multiple spinal bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms.

Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of physical medicine, chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the x-rays.

I have read and I accept the terms above and understand them fully. I hereby give consent to the Advance Health Services, to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

_____ _____
(SIGNATURE) (DATE)

FOR MINORS:

I, _____ being the parent or legal guardian of _____,
(Print Guardian Name) (Print Minor's Name)
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

_____ _____
(SIGNATURE) (RELATIONSHIP TO MINOR

7000 SW 97th Ave #120 Miami Fl 33173 *305 670-0055