COMPREHENSIVE HEALTH HISTORY

Advanced Medical Center
Integrated Health

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: ____________
☐ Internet
☐ TV
☐ Direct Mail
☐ Magazine
☐ 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

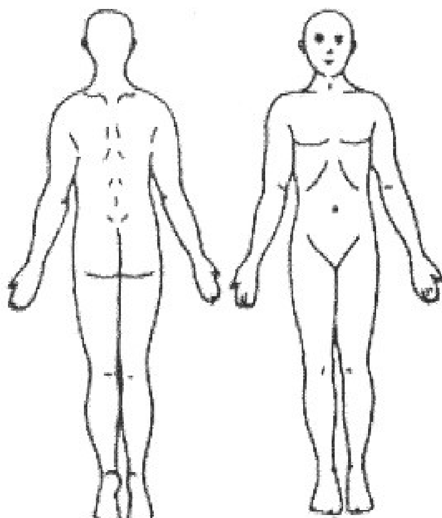
Subscribers Name: ______________________

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 Inquiry ☐ Slip/Fall ☐ Lifting ☐ Slept Wrong ☐ Unknow 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 ____________

Problems #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 ☐ Unknow 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 ____________

Problems #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 ☐ Unknow 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) ____________

COMPREHENSIVE HEALTH HISTORY

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 ?(Tagamet,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

Symptom			
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 Infection	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 ____________

COMPREHENSIVE HEALTH HISTORY

Advanced Medical Center
Integrated Health

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
- ___ Diabetes (non insulin)
- ___ CVA (Stoke)
- ___ 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
- ___ Unspecified. 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 ________________

COMPREHENSIVE HEALTH HISTORY

Advanced Medical Center
Integrated Health

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 I still alive)												
Age at Death (if deceased)												
Cancer												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetis												
Stroke												
Inflammatory Arthritis (ex: Theumatoid Psoriasic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (ex: Lupus, Hashimoto's												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitives or Intolerance												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Disease												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Patient Name ______________________ Patient Signature ______________________ Date ____________

COMPREHENSIVE HEALTH HISTORY

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	
Nail Texture/	1 2 3 4 5
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	
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

Angle/Foot Pain (**Circle all that apply**) Popping, Clicking, Weakness, Stiffness	1 2 3 4 5
Arthritis	1 2 3 4 5
Balance Problems	
Elbow Pain (**Circle all that apply**) Popping, Clicking, Weakness, Stiffness	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Hip Pain (**Circle all that apply**) Popping, Clicking, Weakness, Stiffness	1 2 3 4 5
Joint Pain	1 2 3 4 5
Knee Pain (**Circle all that apply**) Popping, Clicking, Weakness, Stiffness	1 2 3 4 5
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 Wakens You	1 2 3 4 5
Shoulder Pain (**Circle all that apply**) Popping, Clicking, Weakness, Stiffness	1 2 3 4 5
Weakness in Arms/Legs	1 2 3 4 5
Wrist/Hand Pain (**Circle all that apply**) Popping, Clicking, Weakness, Stiffness	1 2 3 4 5

Gastrointestinal

Abdominal Pain/Cramps	1 2 3 4 5
Abnormal Stool	1 2 3 4 5
Bleaching	1 2 3 4 5
Black/Tarry Stools	1 2 3 4 5
Bloating/Gas	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	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

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 ______________

COMPREHENSIVE HEALTH HISTORY

Advanced Medical Center
Integrated Health

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 ANAPPOINTMENT 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 ______________

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 disease or symptoms?

Hypertension (high blood pressure) ?		Pain in upper back (thoracicalgia)?	
Peripheral Vascular Disease?		Pain in lower back (lumbago)?	
Edema (swelling in arm 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 ever 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 OFFENSE ONLY	**Continuous BP (XXX/XX mmHg)**	**BP1:**	**BP2:**	**BP3:**

NEW DAILY NOTE

Advanced Medical Center
Integrated Health

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		
	Continous	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 ______________

MEDICAL CONSENT

Advanced Medical Center
Integrated Health

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.