

**Advanced Holistic Healthcare**

901 Stewart Ave., Suite 285 Garden City, NY 11530

516.742.5715

Patient Name \_\_\_\_\_ Address \_\_\_\_\_ Gender: M F  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ E-mail \_\_\_\_\_  
 Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_  
 Best number and time to reach you? \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**To better serve you please answer the following questions:**

1. What is the main reason you are here? \_\_\_\_\_
2. How do you expect to achieve them? \_\_\_\_\_
3. What are you hoping we can help you with? \_\_\_\_\_

4. Check off the following symptoms or disorders you have and CIRCLE the ones that affect you the most:

- |                     |                               |                            |                          |
|---------------------|-------------------------------|----------------------------|--------------------------|
| Headache/Migraines  | Neck Pain                     | Hip Pain (right or left)   | Chemical Stress          |
| Allergies           | Shoulder Pain (right or left) | Knee pain (right or left)  | Physical Stress          |
| Chest/Rib Pain      | Elbow Pain (right or left)    | Ankle Pain (right or left) | Emotional Stress/Anxiety |
| Dizziness           | Wrist Pain (right or left)    | Muscle Stress              | Attention Disorders      |
| Ear Aches           | Scoliosis                     | Constipation               | Sciatica                 |
| Asthma              | Low Back pain                 | Hyperactivity              | Numbness/Tingling        |
| Frequent Colds/Flu  | Mid-Back Pain                 | Arthritis                  | Leg pain (right or left) |
| Heartburn/Reflux    | Disc Problems                 | Arm pain (right or left)   | Vertigo                  |
| Low Energy/Fatigue  | Insomnia                      | Depression                 | Ulcers                   |
| Weight Gain         | Ringling/Buzzing in Ears      | Bed Wetting                | Autoimmune Disease       |
| Loss of Memory      | High Blood Pressure           | Menstrual Problems         | Diabetes                 |
| Excess Gas/Bloating | Low Blood Pressure            | Thyroid Trouble            | Swollen Ankles           |
| Multiple Sclerosis  | Fibromyalgia                  | Circulatory Problems       | Skin Conditions/Acne     |
| High Cholesterol    | Shortness of Breath           | Nausea                     | Diarrhea                 |
| Bladder Problems    | Cancer                        | Vascular Disorder          | Urinary Difficulty       |
| Digestive Problems  | Heart Condition               | Immune System Disorder     | Sinus Trouble            |
| Infertility         | Kidney Disease                | Mood Swings                | Osteoporosis             |

Other: \_\_\_\_\_

**\*\*\*\*\*Vertebral Subluxations CAUSE Symptoms\*\*\*\*\***

5. Addressing what brought you into this office: (If you have no symptoms or complaints and are here for wellness services, please skip to question 7.)

Please list your health concerns according to their severity	Level of severity 1 – Mild 10 - Severe	When did this episode start?	Have you had this condition before? If so when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					

Which pain or condition is the worst? \_\_\_\_\_

What do you believe is the cause? \_\_\_\_\_

What are you currently doing for it? \_\_\_\_\_

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How long has this condition bothered you? \_\_\_\_\_

Is your pain sharp or dull? \_\_\_\_\_

Do you feel constant or occasional pain? \_\_\_\_\_

Pressure on the spinal cord or nerves can be worse in the AM or the PM. Which is harder for you? \_\_\_\_\_

Does this radiate to an extremity or stay in one area? \_\_\_\_\_

(5a) Are any of the above symptoms linked to a current car accident or workers compensation case? \_\_\_\_\_

6. Please indicate which areas of your life are compromised by your current level of health:

- |                         |                         |   |
|-------------------------|-------------------------|---|
| Bending                 | Housework               | Relationships with Friends              |
| Lifting                 | Yardwork                | Overall sense of wellbeing              |
| Walking                 | Travel                  | Family Relationships                    |
| Sitting                 | Energy Levels           | Way I handle Stress                     |
| Climbing Stairs         | Job Activities          | Overall Moods                           |
| Standing                | Emotional Well-Being    | Patience and Temper                     |
| Running                 | Recreational Activities | Relationship with Significant Other     |
| Exercise                | Memory                  | Relationships with friends Productivity |
| Concentration and Focus | My patience and temper  | Sports and Physical Activities          |
| Weight and Metabolism   | Relationships with Kids |   |

7. Are you bothered by: (Check all that applies)

\_\_\_ Anxiety      \_\_\_ Depression      \_\_\_ Irritability

8. On a scale of 1-10:

- a. Where would you rate your overall health and well-being? \_\_\_\_\_
- b. Where would you want it to be? \_\_\_\_\_ And how long do you think this process will take? \_\_\_\_\_

9. Have you had any experience with chiropractic? YES NO

- a. Did you like the results? YES NO
- b. What did you enjoy most and least about your visits there? \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Employer \_\_\_\_\_

**Occupation** (Please be specific. The work we do can greatly affect our health and/or stress level. This information will help the doctor with your course of care)

\_\_\_\_\_

**Circle one:**    Single            Married            Divorced/Separated            Widowed

Name of Spouse \_\_\_\_\_

Name of children and age(s) \_\_\_\_\_

**Education completed:**      High school                      College Graduate                      Post-Graduate

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**Medical History**

List all physicians and practitioners you have seen for your **current** condition \_\_\_\_\_

Have you had any surgeries? YES NO If so, when and what? \_\_\_\_\_

Do you have any scars? YES NO If yes, where? \_\_\_\_\_

Do you currently have any injuries as a result of an auto or work related accident. If yes, please specify. \_\_\_\_\_

Have you ever been hospitalized? YES NO If yes, why? \_\_\_\_\_

List any medical conditions you currently have: \_\_\_\_\_

List any medications you are currently on: \_\_\_\_\_

If there was a way we can help you come off these medications would you be interested? YES NO

List any known allergies (food, inhalants, etc.) \_\_\_\_\_

Have you ever had any of the following diagnostic tests?

X-rays  MRI scans  Bone scan  CT scan  Myelogram  Disco gram  EMG

If any reason selected, list reason: \_\_\_\_\_

Do you have a history of cancer? YES NO

Are you currently pregnant? YES NO

**Check all that apply:**

Smoker  Non-smoker  Drinks Alcohol  Does not drink alcohol  Takes drugs  Does not take drug

**SOCIAL/FAMILY MEDICAL HISTORY**

Heart Disease  Stroke  Circulatory Disorder  Blood Pressure  Diabetes

Other: \_\_\_\_\_

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**Informed Consent:**

I do hereby authorize the doctors of Advanced Holistic Healthcare to administer care that is necessary for my particular case. This may include consultation, examination, adjustments or any other procedure, which is advisable and necessary for my healthcare. The doctor's here provide a specialized, non-duplicating health care service which includes detecting and correcting spinal subluxations (a misalignment of one or more vertebrae causing a blockage in nerve flow). It is important to note that the doctor does not diagnose, treat or cure disease. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated, however, it is the responsibility of the patient to make it known whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor.

**Acknowledgement**

I have been informed that upon request I can receive a copy of the privacy practices (HIPPA). I am aware that I have an opportunity to discuss my rights to privacy if I please.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent to Evaluate and Treat a Minor:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Communications:**

In the event that we would need to communicate your healthcare information, to who may we do so?

Spouse: \_\_\_\_\_ Children: \_\_\_\_\_ Others: \_\_\_\_\_

**\*\*\*\*FOR WOMEN ONLY\*\*\*\***

**Pregnancy Release:**

This is to certify that to the best of my knowledge I am **NOT pregnant** and the above and doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can harm a fetus (unborn child) in the early stages.

**Date of last menstrual period:** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_