ADVANCED HOLISTIC HEALTH CARE

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	Ringing/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 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? _____

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

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

Advanced Holistic Healthcare
901 Stewart Ave., Suite 285 Garden City, NY 11530 516.742.5715

HEALTH HISTORY OF FAMILY MEMBERS

The reason for this form is to assist the doctor by providing past health history information for their review.

Condition	Father	Mother	Spouse	Brothers	Sisters	Children
Arthritis						
Asthma						
Back Trouble/Disc Problems						
Cancer						
Constipation						
Diabetes						
Drug Addiction						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
High Cholesterol						
Kidney Trouble						
Migraine						
Nervousness						
Pinched Nerve						
Sinus Trouble						
Stomach Trouble/Digestive Issues						
Stroke						
Thyroid Problems						
Deceased						

Advanced Holistic Healthcare
901 Stewart Ave., Suite 285 Garden City, NY 11530 516.742.5715

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:** _____