Patient Name_____Date_____

ADVANCED HEALTH CHIROPRACTIC

Let me be the first to welcome you to our office! Advanced Health Chiropractic is committed to educate, share, and always maintain the highest level of dignity and integrity of the chiropractic profession. This vision is a constant journey to maximizing the health, wellness, and functional performance in every patient. In the chiropractic profession, we emphasize healing occurs above down and inside out of the human body. This ideology of healing is the foundation for which we approach with each and every patient. Your first visit with Advanced Health Chiropractic will consist of a consultation and exam with Dr. Brandon Pounds. The purpose of our consultation is to inform the patient how chiropractic is able to not only reduce the involvement of pains, strains, and sprains; but to express the impact chiropractic has in reducing interference to the nervous system, thus, allowing your body to function at its optimum capacity.

At Advanced Health Chiropractic we believe every person was born to live life abundantly. Advanced Health Chiropractic is a family environment and all friends, colleagues, and family members are encouraged to join you on your visit. Thank you for visiting Advanced Health Chiropractic, we look forward to working with you.

Best regards,

Dr. Brandon Pounds
Advanced Health Chiropractic

Patient Name_____Date_____

Chiropractor Intake Form

Title: (Circle one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. □ Other_____

First Name_____Middle Initial_____Last Name_____

Address_____City _____State_____Zip Code_____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Email:_____

Date of Birth _____/_____/_____ Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Other

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____-_____ Cell Phone (_____)_____-_____

Employer Data

Employment Status: □ Employed □ Unemployed □ Student □ Other_____

Employer _____Your Occupation _____

Doctor's Signature _____

ADVANCED HEALTH CHIROPRACTIC

Patient Name_____Date_____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Hypertension ☐ Psychiatric Illness ☐ Skin Disorder ☐ Stroke
☐ Fibromyalgia ☐ Asthma ☐ Osteoporosis ☐ Other_____

Surgeries: (Circle all that apply to you)

☐ Appendectomy ☐ Joint Replacement ☐ Cervical spine
☐ Hysterectomy ☐ Cardiovascular procedure ☐ Prostate
☐ Lumbar spine ☐ Joint Replacement ☐ Gall Bladder
☐ Brain ☐ Shoulder ☐ Thoracic spine
☐ Knee ☐ Carpal Tunnel ☐ Gastro-intestinal
☐ Uro-genital ☐ Breast Augmentation ☐ Hernia
☐ Other _____

Social History: (Circle all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Drink Water:	☐ <64 oz/day	☐>64 oz/day	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Sleep:	☐ <8 hours/night	☐ >=8 hours/night	☐ Insomnia

Family History: (Circle all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease:	☐ Parent	☐ Sibling
Hypertension:	☐ Parent	☐ Sibling
Stroke:	☐ Parent	☐ Sibling
Thyroid:	☐ Parent	☐ Sibling

Allergies: (Circle all that apply to you)

☐ Mold
☐ Seasonal
☐ Milk or Lactose
☐ Animal
☐ Wheat/Glutens
☐ Chemical _____
☐ Other _____

Doctor's Signature_____

ADVANCED HEALTH CHIROPRACTIC

Patient Name_____Date_____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular:

☐ Poor Circulation ☐ Hypertension ☐ Heart Disease ☐ Heart Attack
☐ Chest Pain ☐ High Cholesterol ☐ Pace Maker ☐ Jaw Pain
☐ Irregular Heart Beat ☐ Swelling in legs

Respiratory:

☐ Asthma ☐ Tuberculosis ☐Short Breath ☐ Emphysema
☐ Cold/Flu ☐Cough ☐ Wheezing

Eyes / Ear / Nose / Throat:

☐ Glaucoma ☐ Double Vision ☐ Blurred Vision ☐ Loss of Vision
☐ Dizziness ☐ Hearing Loss ☐ Nosebleeds ☐ Difficulty
☐ Sore Throat ☐ Bleeding Gum ☐ Sinus Infections

Genitourinary/Gastrointestinal:

☐ Kidney Disease ☐ Burning Urination ☐ Frequent Urination
☐ Blood in Urine ☐ Kidney Stones ☐ Flank Pain
☐ Gall Bladder Pain ☐ Bowel Inconsistency ☐ Constipation ☐ Ulcers
☐ Liver Pain ☐ Nausea/Vomiting ☐ Bloody Stools ☐ Diarrhea

Musculoskeletal:

☐ Arthritis ☐ Joint Stiffness ☐ Muscle Weakness ☐ Gout
☐ Osteoporosis ☐ Broken Bones ☐ Pain (indicate area:_____)

Neurologic:

☐ Stroke ☐ Head Injury ☐ Aneurysm ☐ Numbness ☐ Vertigo
☐ Headache ☐ Parkinson's ☐ Carpal Tunnel ☐ Sciatic ☐ Seizures

Hematologic:

☐ Hepatitis ☐ Blood Clots ☐ Cancer ☐ Bruising
☐ Bleeding ☐ Fever, Chills ☐ Sweating ☐ Varicose Veins

Doctor's Signature_____

ADVANCED HEALTH CHIROPRACTIC

Patient Name_____Date_____

Please list all current medications being taken_____

Are You Pregnant? (Check) Yes No

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

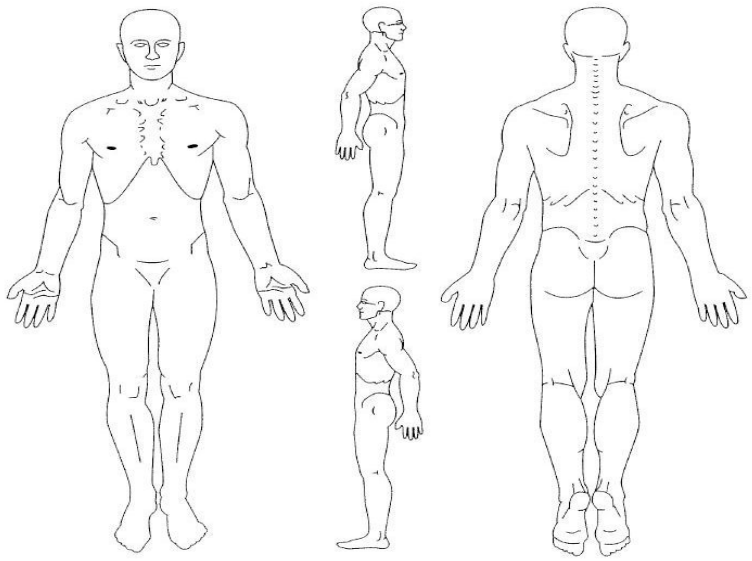
N=Numbness

B=Burning

S=Sharp

T=Tingling

A=Dull/Ache



Average Pain Intensity: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? □Yes □No If Yes, please list:_____

When did your symptoms begin?_____

How did your symptoms begin?_____

How often do you experience your symptoms?

□ Constantly □ Frequently □ Occasionally □ Intermittently

What describes the nature of your symptoms.

□ Sharp □ Dull/Achey □ Numb □ Shooting
□ Burning □ Tingling □Throbbing □ Other:_____

Doctor's Signature_____

ADVANCED HEALTH CHIROPRACTIC

Patient Name_____Date_____

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and chiropractic procedures including various modes of physical therapy, and if necessary diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible:_____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Advanced Health Chiropractic and/or other licensed Doctors of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Brandon Pounds and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels are in the best interests at the time, based upon the facts then known. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent from to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by patient:

_____

Print Patient's Name

_____

Signature of Patient

Date:_____/_____/_____

To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)

_____

Print Name of Representative

_____

Signature of Representative

Date:_____/_____/_____

ADVANCED HEALTH CHIROPRACTIC