ADVANCED SPINAL HEALTH, LLC

Optimizing Your Health Through Chiropractic and Nutrition

Gregory R. Heyart, DC

Patient Information Date: _____

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Would You like Text Reminders? Y N If so, Cell Phone Carrier: _____

Email: _____ Email Appt Reminder? Y N

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Employer: _____ Occupation: _____

Spouse: _____ Spouse DOB: _____

Person responsible for this account: _____ Phone: _____

Who may we thank for referring you? _____

Emergency Contact Name: _____ Phone: _____

Major Complaint: _____

_____

Other Complaints: _____

How long have you had this condition? _____ Have you had similar conditions in the past? Y N

What activities aggravate this condition? _____

Is this condition getting progressively worse? Y N Constant Comes & Goes

Does this condition interfere with your: Work Sleep Daily Routine Other: _____

How long since you felt really good? _____

List Surgical Procedures: _____

Medications You are Taking: _____

Non-Prescription Drugs: _____

Other Doctors Seen for this Condition: _____ Diagnosis: _____

X-Rays Last Taken: _____ Other Tests Taken: _____

Have You Been Off Work? Y N If So, How Long? _____ When Did You Return to Work? _____

PLEASE TURN OVER

Primary Insurance Information

Company: _____ ID#: _____

Secondary Insurance Information

Company: _____ ID#: _____

Accident Information (If Applicable)

Did your accident occur at work? Y N Were you involved in an auto accident? Y N

(Please tell the front desk, if you answered yes to any of these questions.)

If yes to either, Date: _____ Time: _____

Personal injuries occurring in the last year: _____

Past Five Years: _____

Please Check Areas of Concern:

HEAD
☐ sinus
☐ entire head
☐ back of head
☐ forehead
☐ temples
☐ migraine
☐ head feels heavy
☐ loss of memory
☐ lightheaded
☐ fainting
☐ light bothers eyes
☐ blurred vision
☐ double vision
☐ loss of vision
☐ loss of taste
☐ loss of balance
☐ dizziness
☐ loss of hearing
☐ pain in ears
☐ ringing in ears
☐ buzzing in ears

NECK
☐ pain
☐ neck pain w/movement
☐ forward
☐ backward
☐ turn to left
☐ turn to right
☐ bend to right
☐ pinched nerve in neck
☐ neck feels out of place
☐ muscle spasms in neck
☐ grinding sounds in neck
☐ popping sounds in neck
☐ arthritis in neck

MID BACK
☐ pain
☐ locations
☐ sharp stabbing
☐ dull ache
☐ muscle spasms
☐ pain in kidney area

ARMS/HANDS
☐ pain in upper arm
☐ pain in elbow
☐ pain in hands
☐ pain in fingers
☐ numbness
☐ fingers go to sleep
☐ hands cold
☐ swollen joints
☐ sore joints in fingers

ABDOMEN
☐ nervous stomach
☐ nausea
☐ constipation
☐ diarrhea

CHEST
☐ pain
☐ shortness of breath
☐ pain around ribs
☐ breast pain
☐ irregular heartbeat

HIPS, LEGS, FEET
☐ buttock pain
☐ hip joint pain
☐ muscle spasms
☐ pain down leg
☐ cold feet
☐ cramps
☐ swollen feet/ankles

WOMEN ONLY
☐ menstrual pain
☐ cramping
☐ irregular cycles
☐ taking birth control
☐ hysterectomy
☐ menopause
☐ ARE YOU PREGNANT?

MEN ONLY
☐ urinary frequency
☐ difficulty starting
☐ night urination
☐ prostate pain/swelling

GENERAL
☐ nervousness
☐ irritability
☐ depression
☐ fatigue
☐ run down feeling
☐ loss of sleep
☐ weight gain
☐ weight loss
☐ smoker
☐ diabetes
☐ hypoglycemia

REMARKS

_____

_____

_____

_____

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that an interest fee at 18% per annum will be charged on any balance over 30 days in addition to a $10 per month LATE FEE on any balance over 60 days. I agree to pay for all fees incurred, and in the event of default, agree to pay reasonable collection charges and/or attorney fees. I further understand that if I suspend or terminate my care and treatment, any fees will be immediately due and payable.

Signature: _____

Date: _____